

## INTERIM CERTIFICATION STANDARDS



CT DMHAS  
Interim MHR  
Certification Standards



In September, 2002, DMHAS formally designated the concept of recovery as an overarching goal of the service system. Recovery is defined as: “a process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and then rebuilding one’s life despite, or within the limitations imposed by that condition.” This definition talks about an approach to care and the rebuilding of a self that is individualized and involved. Together; the DMHAS initiatives; a changing provider system and the client will bring about the transformations that will be structured, long term and individually focused.

DMHAS has made a commitment to implement the Medicaid Rehabilitation Option to support and reinforce the Recovery Initiative. Key areas of congruence include:

- Treatment planning that incorporates client goals and strengths as key components
- An emphasis on assisting clients to reach their highest level of functioning and independence
- Client participation in the planning and delivery of services
- An emphasis on providing services in settings and schedules of the client’s choice
- Assisting the client to develop and use natural supports and support systems apart from the health care system
- A focus on developing skills and strengths to succeed in natural environments, including school, work and home.
- Services delivered based on client need rather than program requirements.

Because Medicaid is a health insurance program, certain requirements must be met for MRO services to be billed to Medicaid. Clients will participate with providers in developing treatment plans that focus on overcoming the effects of the psychiatric or co-occurring disorders, and billable Medicaid services must focus on the goals and objectives developed by the client and provider in the treatment plan. Providers must be certified by DMHAS as to their understanding of the rehabilitative services and their ability to accommodate to the regulations promulgated by Medicaid.

The goals of the certification process reflect the Department’s desire to continue the development of a recovery-focused provider system using the Medicaid Rehabilitation Option to build strength-based services throughout the system.

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The Commissioner of the Department of Mental Health and Addiction Services (DMHAS), pursuant to the authority set forth in House Bill 7000 hereby sets forth the rules that DMHAS shall use to certify community-based providers of mental health rehabilitation services (MHRS) and implement the Medicaid Rehabilitation Option for Mental Health Rehabilitation Services (MHRS).

## **MENTAL HEALTH REHABILITATION SERVICES PROVIDER INTERIM CERTIFICATION STANDARDS**

### **GENERAL PROVISIONS**

The Department of Mental Health and Addiction Services has entered into a Memorandum of Agreement with the Department of Social Services (DSS) to implement a Medicaid Rehabilitation Option for the provision of mental health rehabilitative services to adults.

Each DMHAS-interim certified MHRS provider shall meet and adhere to the terms and conditions of its Human Services Agreement with DMHAS and its Medicaid provider agreement with DSS. All conditions of this certification will become conditions of the Human Services Agreement with DMHAS.

### **1. MHRS PROVIDER INTERIM CERTIFICATION PROCESS**

#### **1.1. Overview of Interim Process**

All standards in this document apply to Interim Certification as an MHRS provider. This Interim Certification will serve as an initial indication of which Connecticut behavioral health providers are willing and qualified to deliver services once Connecticut implements the Medicaid Rehabilitation Option for ACT and Community Support. During the implementation phase for new services, DMHAS shall conduct an interim certification process using guidelines and processes outlined in this document. This interim process shall also serve as an initial application by providers to participate in the MHRS.

The interim certification process evaluates both those standards that agencies are meeting currently, and the agency's plans for becoming fully compliant with standards by October 1, 2007.

For clarity, the term "certification" used in this document shall apply to Interim Certification unless it is specifically qualified as "final certification."

#### **1.2. Types of certification.**

Each applicant seeking certification as an MHRS provider shall submit a certification application to DMHAS. Certification is required for type of provider (Core or Specialty) and for each specific MHRS service to be delivered by the provider. The purpose of the certification process is to ensure that providers meet all requirements to deliver

coordinated, quality community-based rehabilitation services in alignment with DMHAS' vision of comprehensive, recovery-oriented care.

**1.3. Final Certification Process.**

Future guidance will be issued outlining the process and requirements for providers with interim MHRS certification to apply for full certification as providers of MHRS services for DMHAS and as Medicaid Rehabilitation Option providers.

**1.4. Eligible Providers.**

Any entity having a contract with DMHAS for the provision of mental health services, other than hospital inpatient units, Federally Qualified Health Centers, and Institutes of Mental Disease, may apply for certification as a MHRS provider. An applicant/provider that has been decertified by Medicare or Medicaid shall not be eligible for interim MHRS certification.

**1.5. Incomplete applications.**

Upon receipt of a certification application, DMHAS shall review the certification application to determine if it is complete. If a certification application is incomplete, DMHAS shall return the incomplete certification application to the applicant. An incomplete certification application shall not be regarded as a certification application, and return of the incomplete certification application and DMHAS's failure to take further action to issue certification to the applicant shall not constitute denial of an application for certification or renewal of certification.

**1.6. Review of application.**

Following DMHAS's acceptance of the certification application, DMHAS shall determine whether the applicant's services and activities meet the certification standards described in this document. DMHAS may schedule and conduct an on-site survey of the applicant's services to determine whether the applicant satisfies all the certification standards. DMHAS may conduct an on-site survey at the time of certification application or certification renewal, or at any other time with appropriate notice, and shall have access to all records necessary to verify compliance with certification standards, and may conduct interviews with staff, others in the community, and consumers with consumer permission.

**1.7. Issuance of certification.**

DMHAS shall issue interim certification to each applicant complying with the certification standards.

**1.8. Adding services.**

If a DMHAS-certified MHRS provider desires to add an MHRS service during the term of interim certification, the MHRS provider shall submit a certification application describing the service. Upon determination by DMHAS that the service is in compliance with certification standards, DMHAS shall certify the MHRS provider to provide that service.

**1.9. Length of certification.**

Interim certification as an MHRS provider shall remain in effect until final certification processes are instituted. At that time, all providers with interim certification must apply for final certification as an MHRS provider and complete the Medicaid enrollment process for the certified services. Interim certification shall specify the effective date of the certification, whether the MHRS provider is certified as a Core or Specialty provider, and the types of services the MHRS provider is certified to provide.

**1.10. General certification requirements.**

Certification is not transferable to any other organization.

The MHRS provider shall notify DMHAS immediately of any changes in its operation that affects the MHRS provider's continued compliance with these certification standards, including changes in ownership or control, changes in service and changes in its affiliation and referral arrangements, and/or changes in accreditation status.

**1.11. Termination of certification.**

The Commissioner may deny or revoke certification if the applicant or MHRS provider fails to comply with any certification standard.

Certification shall be considered terminated and invalid if the MHRS provider fails to apply for renewal of certification prior to the expiration date of the certification, voluntarily relinquishes certification, or goes out of business.

**1.12. Appeals Process**

An applicant or provider may appeal a refusal to issue certification or revocation of certification to DMHAS.

If DMHAS determines that certification or recertification should not be issued or that certification should be revoked, DMHAS shall send, by certified mail, return receipt requested, written notice to the provider within 30 days after the determination. The notice shall contain the specific requirements with which the applicant or provider has not complied, DMHAS's proposed action, and the applicant or provider rights as follows:

- If the applicant chooses to appeal the decision, the applicant or provider shall submit a written request for a consideration of appeal within 20 days after the dated receipt of the notice, sent by certified mail, return receipt requested.
- If the applicant does not submit a request for a hearing, as provided in this document, or if, after conducting the hearing, DMHAS determines that the certification should not be issued or that the certification should be revoked, DMHAS shall issue an order to that effect.

## **2. SERVICE COVERAGE**

### **2.1. General.**

MHRS are those rehabilitative services administered by DMHAS and rendered during the interim certification period by DMHAS-certified MHRS providers to eligible consumers who require such services.

MHRS are intended for the maximum reduction of mental disability and restoration of a consumer to his or her best possible functional level.

MHRS are recommended by a Licensed Practitioner of the Healing Arts and rendered by credentialed staff, under the supervision of licensed clinicians, in certified rehabilitation services agencies in accordance with the certification standards established in this document.

### **2.2. Covered services.**

Rehabilitative services covered as MHRS are:

- Assertive Community Treatment
- Community Support Team
- Residential Rehabilitation in a Mental Health Group Home

Eligible consumers of MHRS shall meet eligibility requirements established in Section 4.

Eligible MHRS providers include Core Providers and Specialty Providers that are certified in compliance with the certification standards set forth in this Document.

### **2.3. Coverage limitations.**

Coverage for any MHRS is contingent on whether all of the following criteria are met:

- (a) The service shall be medically necessary;
- (b) The service shall be delivered by a DMHAS-certified MHRS provider as described in this document.
- (c) The service shall be delivered by licensed clinicians (and credentialed staff under the supervision of licensed clinicians) acting within their scope of practice.
- (d) The service shall be delivered in accordance with an approved treatment plan as described in Section 9; and
- (e) The service shall be delivered in accordance with the service specific standards set forth in Sections 3.2, 11, and 12.

### **2.4. Grievance.**

All clients receiving MHRS shall have the right to file a grievance with DMHAS and shall receive fair hearing rights and notice of such rights in accordance with processes

established by DMHAS and incorporated into Part II of the Connecticut Human Service Contract.

### **3. ELIGIBLE CONSUMERS**

Eligible consumers of MHRS include adults with a primary mental illness or a co-occurring mental illness and addictive disorder and certified as requiring MHRS by a Licensed Practitioner of the Healing Arts within a DMHAS Certified Core Provider.

Eligible consumers of MHRS shall have a primary mental health diagnosis on Axis 1 of the DSM-IV.

Individuals with the following conditions are not eligible consumers of MHRS unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance-related disorder.

### **4. CONSUMER CHOICE**

#### **4.1. Choice of providers.**

All clients receiving MHRS shall have free choice of DMHAS-certified MHRS providers.

#### **4.2. Consumer Choice Policy.**

Each MHRS provider shall establish and adhere to policies and procedures governing the means by which consumers shall be informed of the full choices of MHRS providers, licensed clinicians and other mental health service providers available, including information about peer support and family support services and groups and how to access these services (MH Consumer Choice Policy).

DMHAS shall review and approve each MHRS provider's MH Consumer Choice Policy during the certification process if the provider meets the standards and guidelines for choice.

Each MHRS provider shall make its MH Consumer Choice Policy available to consumers and their families (whenever appropriate for families) and shall establish and adhere to a system for documenting that consumers and families receive the MH Consumer Choice Policy.

##### **4.2.1. Core Providers' MH Consumer Choice Policy**

Each Core Provider's MH Consumer Choice Policy shall ensure that each enrolled consumer:

- (a) Requesting MHRS directly from the Core Provider is informed that the consumer may choose to have MHRS provided by any DMHAS-certified Core Providers; and
- (b) Is informed that the consumer may choose to have specialty MHRS provided by any of the DMHAS-certified specialty providers that have entered into affiliation agreements with that Core Provider.

#### **4.2.2. Specialty Providers' MH Consumer Choice Policy.**

Each specialty provider's MH Consumer Choice Policy shall ensure that each consumer not enrolled in a Core Provider and requesting MHRS directly from the specialty provider is informed that the client has a choice of Core Providers with whom the Specialty Provider has Affiliation Agreements, and is referred to the Core Provider of their choice for assessment and treatment planning.

## **5. CORE PROVIDERS**

### **5.1. Minimum requirements and Clinical Home.**

Core Providers serve as the clinical home for all clients involved in MHRS. At a minimum, Core providers must:

- Have active accreditation by a national accrediting body, including JCAHO, CARF or COA.
- On staff, have the direct capacity to provide the following clinical services to clients:
  - Diagnosis by a Licensed Practitioner of the Healing Arts (LPHA)
  - Comprehensive Assessment, including biopsychosocial, psychiatric, addictions, and functional abilities
  - Master treatment planning (Based on the diagnosis and comprehensive assessment, establishing – with the client – broad recovery goals and the services required to achieve those goals. For those services that are Medicaid funded, establishing medical necessity.)
  - Master treatment plan coordination, monitoring, review and updating in coordination with all providers delivering service and in accordance with the client's recovery goals.
  - Psychiatric medication assessment, prescription, and ongoing medication management.
  - Counseling and/or psychotherapy.
  - Community Support Team.
  - Must offer, either directly or through contract, access to a clinician for review of any crisis on a 24 hour, 7-day a week, and 365-day a year basis to enrolled clients. For ACT clients, there must be an alert system developed to notify on-call ACT staff and the Crisis Teams that a client may require special services.
- Be a participating Medicaid provider in good standing in the State of Connecticut.
- Meet timelines for treatment planning and review (and all other requirements, including clinical management/utilization management) of all enrolled clients, both

for services provided internally and through specialty providers with which the Core Provider has an affiliation agreement.

- Enter into affiliation agreements with specialty providers delivering MHRS services and ensure that coordination of care and ongoing clinical communication is maintained to meet the needs of those clients.
- Ensure that all MHRS clients receiving treatment from the Core Provider shall have a primary contact person from the Core Provider's staff. In cases where the client is receiving Community Support Team or ACT services from the Core Provider, the primary contact person shall be the client's primary contact on the team. In cases where there are multiple services offered, the primary contact person shall be part of the client's treatment team at the Core Provider.
- Maintain listings, in a manner determined by DMHAS, of all current enrolled clients, along with each client's primary contact with the Core agency, and any specialty providers delivering mental health services to each client.

## **5.2. Staffing**

Each Core Provider shall satisfy the following minimum staffing requirements:

- 5.2.1.** A Medical Director who is a board-eligible psychiatrist, responsible for the quality of medical and psychiatric care provided by the MHRS provider.
- 5.2.2.** A Clinical Director who is a licensed clinician in Connecticut with an appropriate, relevant behavioral health advanced degree, with overall responsibility for oversight of the clinical program of the MHRS Core provider. The Clinical Director may also serve as the Medical Director if the Clinical Director is a board-eligible psychiatrist;
- 5.2.3.** All staffing required by specific MHRS service definitions as outlined in the definitions for the MRO Services.

## **5.3. Service Accessibility Standards.**

Each MHRS Core Provider shall comply with the following requirements regarding service accessibility:

- 5.3.1.** Each MHRS Core Provider shall ensure that its business hours are accessible to clients and facilitate each enrolled client's ability to choose an MHRS provider.
- 5.3.2.** Each potential consumer presenting with an urgent need shall be provided an appointment by a Core Provider with a licensed clinician for a face-to-face intervention within the same day that the consumer presents for service.
- 5.3.3.** Each potential consumer presenting with a routine need shall be provided an intake appointment by a Core Provider for an intake appointment within seven (7) business days of presentation for service.

**5.3.4.** Appointments for the purpose of reviewing and updating Master Treatment Plans for clients who are also being seen by affiliated providers must be made available no later than two weeks prior to the due date of the MTP review.

**5.4.** The Master Treatment Plan must be sent to the Specialty Providers prior to the due date so that the Specialty Providers may stay current in their billing.

## **6. SPECIALTY PROVIDERS**

**6.1.** Definition.

Specialty providers are certified to deliver one or more of the MHRS services to DMHAS clients who are enrolled with a Core Provider. Specialty Providers deliver medically necessary services under the direction of a treatment plan developed by the client and Core Provider.

**6.2.** Affiliation Agreements.

Each specialty provider shall establish and adhere to policies and procedures governing its relationship with a Core Provider which address access to records, clinical responsibilities, legal liability, dispute resolution, and all other MHRS certification standards and which are outlined in an Affiliation Agreement with that Core Provider (Affiliation Policy).

**6.3.** Accreditation.

Specialty Providers must either be accredited by a national accrediting body (JCAHO, CARF or COA) OR meet the additional certification requirements listed in Appendix B.

**6.4.** Treatment Planning.

Specialty providers must have the ability to contribute to and/or coordinate treatment planning with the Core Provider, the ability to develop specialty service-specific objectives with the client that assist in achieving goals on the Master Treatment Plan, the ability to use functional assessment and other appropriate tools with clients to expand comprehensive assessments performed by Core Provider and to assist in building client-centered specialty-service objectives and interventions.

**6.5.** Required Staffing.

Each specialty provider shall satisfy the following minimum staffing requirements:

**6.5.1.** A Clinical Director who is a licensed clinician with overall responsibility for oversight of the MHRS program of the specialty provider.

**6.5.2.** The Clinical Director may also serve as the Community Support Team Leader if there is only one Community Support team and one MHRS service provided by the Specialty provider AND the team leader is a licensed clinician.

**6.5.3.** All staffing as required by specific MHRS service definitions.

## **6.6. Accessibility Standards.**

Each MHRS Specialty Provider shall comply with the following requirements regarding service accessibility:

- 6.6.1.** Each MHRS Specialty Provider shall ensure that its business hours are accessible to clients.
- 6.6.2.** Each potential consumer presenting with a routine need shall be provided an initial appointment by a Specialty Provider within seven (7) business days.
- 6.6.3.** Specialty providers that are unable to initiate services to new clients within seven (7) business days shall notify the Core Provider and refer the client to other specialty providers in the area.

## **7. REQUIREMENTS FOR ANY CERTIFIED MHRS PROVIDER**

The following requirements are applicable to any certified MHRS provider, whether Core or Specialty. Requirements specific to Core and Specialty Providers are outlined in Sections 5 and 6.

### **7.1. Coordination with Other Providers**

All MHRS providers are responsible to ensure that coordination of care – including treatment planning, clinical management, and assessments – occurs efficiently and effectively with all affiliated providers. MHRS Core Providers have the affirmative responsibility to initiate and manage coordination of care with any specialty providers delivering MHRS services in conjunction with the Core Provider.

#### **7.1.1. Central Communication & Coordination Link.**

MHRS providers must establish a central communications and coordination contact link with affiliated core and/or specialty providers. For Core providers, this may be each client's designated primary contact person at the Core Provider, or a designated contact for multiple clients. For Specialty Providers, the designated link shall be the client's primary contact within the Mental Health Group Home, the Assertive Community Treatment Team, or the Community Support Team.

#### **7.1.2. Treatment Planning Collaboration.**

Each Core provider shall establish policies and procedures governing its collaboration with affiliated specialty Providers in the development, implementation, evaluation, and revision of each client's Master Treatment Plan and Rehabilitation Plans, as appropriate. This Policy shall require Core Providers to actively engage with Specialty Providers to meet the treatment planning development, implementation, evaluation, and revision needs of each shared client in a timely manner; and require Core providers to coordinate the client's treatment with the client's primary contact at the Specialty Provider.

Each specialty provider shall establish policies and procedures governing its collaboration with a referring Core Provider in the development, implementation,

evaluation, and revision of each client's Master Treatment Plan and Rehabilitation Plans, as appropriate that comply with DMHAS rules (Collaboration Policy). The Collaboration Policy shall:

- Be part of specialty provider's Treatment Planning Policy;
- Require specialty providers to incorporate Core Provider-developed Diagnostic Assessment material and Master Treatment Plans into specialty provider's treatment planning process; and
- Require specialty providers to coordinate the client's treatment with the client's primary contact at the Core Provider.

#### **7.2. Annual audit.**

Each MHRS Provider shall have an annual audit for all program funds, whether state awarded or not, by a certified public accounting firm, and the resulting audit report shall be consistent with formats recommended by the American Institute of Public Accountants. Each certified provider shall submit such audit report, including recommendations, to the Department within six months of the close of the provider's fiscal year. The department reserves the right to receive a copy of any audit for related parties under common control. Certified provider shall maintain all fiscal records and accounts for three years after the end of the contract year, or until the State Auditors of Public Accounts complete an audit of the department for such fiscal year, whichever is later. The State Auditors of Public Accounts shall have access to such fiscal records and accounts during such period.

#### **7.3. Affiliation Agreements.**

Each Core Provider shall establish formal, written agreements of clinical coordination and communication with specialty providers that outlines the responsibilities of the parties. The Affiliation Agreements shall address, at a minimum, access to records, clinical responsibility, treatment planning, clinical management, timelines, timeframes, and dispute resolution.

#### **7.4. Clinical Management & Information System.**

Each Core and Specialty Provider shall be responsible for submitting all required information to DMHAS for client tracking and clinical management purposes within designated timeframes.

#### **7.5. Recovery Competence**

Each MHRS provider must have and implement a Recovery Competence Plan that has been approved by the department. Recovery competence means a system of policies, skills and attitudes that enable an agency or program to provide client services in a manner that effectively promotes recovery, encourages consumer participation, and choice. Such Plan shall detail the provider's strategies for incorporating recovery standards and guidelines as defined by the department into service delivery and program development. Such strategies shall, at a minimum, address the areas of quality improvement and monitoring, human resource development, information management and decision support, clinical and administrative policies, and governance.

## **7.6. Cultural and Language Competence**

All certified MHRS providers should ensure that clients receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with the consumers' cultural health beliefs and practices and preferred language.

**7.6.1.** The MHRS provider shall develop and implement a Cultural Competence Plan in the form and manner designated by the department. Cultural competence means a system of policies, skills and attitudes that enable an agency or program to provide client services in a manner that effectively responds to differences in cultural beliefs, behaviors and learning and communication styles. Such Plan shall detail the provider's strategies for incorporating cultural competence into service delivery and program development. Such strategies shall, at a minimum, address the areas of quality improvement and monitoring, human resource development, information management and decision support, and governance.

## **7.7. Consumer Protections**

**7.7.1.** Each MHRS provider shall have a statement of consumer rights and responsibilities authorized by its governing authority (Consumer Rights Statement). The Consumer Rights Statement shall be consistent with federal and Connecticut laws and regulations and posted in strategic and conspicuous areas to maximize consumer, family and staff awareness.

**7.7.2.** Each MHRS provider shall establish and adhere to a system for distributing the Consumer Rights Statement which ensures that all clients receive the Consumer Rights Statement during the intake process. Each MHRS provider shall document that the Consumer Rights Statement is distributed to all consumers.

**7.7.3.** Each MHRS provider shall establish and adhere to a well-publicized complaint and grievance system, which includes written policies and procedures for handling consumer, family, and practitioner complaints and grievances (Complaint and Grievance Policy). Each MHRS provider's Complaint and Grievance Policy shall:

- Outline a formal grievance procedure that is acceptable to the Department to address the complaints of persons requesting or receiving services under this contract.
- Designate a Client Rights Officer to manage the grievance process.
- Ensure prominent display of a summary of the grievance procedure in areas that are easily accessible to clients. Such summary shall include the name and telephone number of the Client Rights Officer and the toll free telephone number of the Department's Client Rights and Grievance Office.

**7.7.4.** Each MHRS provider shall establish and adhere to policies and procedures for obtaining written informed consent to treatment from consumers (Consent to

Treatment Policy) which comply with applicable federal and Connecticut laws and regulations.

- 7.7.5.** Each MHRS provider shall establish and adhere to policies and procedures governing the release of mental health information about consumers (Release of Consumer Information Policy), which comply with applicable Federal and Connecticut laws and regulations (HIPPA). For consumers with co-occurring psychiatric and addictive disorders, the MHRS provider shall comply with the requirements of 42 CFR Part II governing the confidentiality and release of drug and alcohol treatment records.

**7.8. Maintaining certification, provider status & contracts**

Each MHRS provider shall comply with the following requirements for maintaining certification, provider status, and contracts:

- 7.8.1.** Maintain proof of DMHAS certification;
- 7.8.2.** Maintain an active Medicaid provider status at all times if offering services to Medicaid-eligible consumers;
- 7.8.3.** Document referral arrangements in writing, using the DMHAS-approved affiliation agreement;
- 7.8.4.** Maintain copies of contracts with DMHAS, vendors, suppliers, and independent contractors; and
- 7.8.5.** Require that its subcontractors continuously comply with the provisions of the MHRS provider's Human Service Contracts with DMHAS.

**7.9. Insurance Coverage**

Each MHRS provider, at its expense, shall carry insurance, (liability, fidelity bonding or surety bonding and/or other), during the term of this contract according to the nature of the work to be performed to "save harmless" the State of Connecticut from any claims, suits or demands that may be asserted against it by reason of any act or omission of the contractor, subcontractor or employees in providing services hereunder, including but not limited to any claims or demands for malpractice. Certificates of such insurance shall be filed with the department prior to the performance of services.

**7.10. Billing and Payment**

Each MHRS provider shall establish and adhere to policies and procedures governing billing and payment for MHRS (Billing and Payment Policy). The Billing and Payment Policy shall require the MHRS provider to have the necessary operational capacity to submit claims, document information on services provided, and track payments received. This operational capacity shall include the ability to:

- 7.10.1.** Verify eligibility for Medicaid and other third party payers;
- 7.10.2.** Document MHRS provided (by MHRS provider staff and any subcontractors);
- 7.10.3.** Submit claims and documentation of MHRS on a timely basis;
- 7.10.4.** Track payments for all MHRS provided services to enrolled or referred clients;

**7.10.5.** Maintain and submit any necessary information to DMHAS.

**7.11.** Sliding Fee Scale

Each MHRS provider shall have an established sliding fee schedule covering each of the MHRS it provides. For services provided to Medicaid-eligible consumers, no additional charge shall be imposed for services beyond that paid by Medicaid.

**7.12.** Corporate Compliance

Each MHRS Core provider shall establish and adhere to a plan for ensuring compliance with applicable federal and Connecticut laws and regulations (Corporate Compliance Plan).

**7.13.** Whenever feasible, each MHRS provider's main service site shall be located within reasonable walking distance of public transportation.

**7.14.** Records Retention.

The contractor shall maintain books, records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of this contract. These records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the state or, where applicable, federal agencies. The contractor shall retain all such records concerning this contract for a period of three (3) years after the completion and submission to the state of the contractor's annual financial audit.

## **8. TREATMENT PLANNING PROCESS**

**8.1.** Responsibility

The Core Provider has the overall responsibility for developing, reviewing, and maintaining each enrolled client's Master Treatment Plan. The Master Treatment Plan links directly to the client's goals and to the diagnostic assessment, and serves as an order for any MHRS services received by the client. Each Core Provider shall coordinate the Master Treatment Planning process for its enrolled consumers.

Specialty Providers are responsible for working with the client to expand the goals on the Master Treatment Plan into a service-specific rehabilitation plan that outlines the objectives to be addressed in that specialty service.

**8.2.** Process components.

The treatment planning process for clients shall, at a minimum, include:

- The completion of a Diagnostic/Assessment process and required components; Section 9.4.
- Development of a Master Treatment Plan which links to the client's goals and the diagnostic assessment and orders MHRS services; Section 9.5.

- Development of an Service-Specific Rehabilitation Plan by any specialty provider providing Residential Rehabilitation in a Mental Health Group Home or Community Support Team.

### **8.3. Involvement.**

The client is the owner of the treatment plan and, at a minimum, participates in the development of goals, objectives, and choices of services. The signature is not enough to guarantee the involvement of the client; the record must demonstrate the active process.

### **8.4. Diagnostic Assessment Process**

#### **8.4.1. Definition.**

A Diagnostic/Assessment is an intensive clinical and functional evaluation of a client's mental health condition that results in the issuance of a Diagnostic Assessment report with recommendations for service delivery that provides the basis for the development of a MTP.

#### **8.4.2. A Diagnostic/Assessment shall:**

- Determine whether the client is appropriate for and can benefit from MHRS based upon the client's diagnosis, presenting problems, and recovery goals; and
- Evaluate the client's level of readiness and motivation to engage in treatment, and
- Be conducted and signed by a Licensed Practitioner of the Healing Arts.
- In updating Diagnostic Assessments, information from other members of the client's treatment team, especially as to the client's actual functioning in natural settings, shall be incorporated into the Diagnostic Assessment formulation.

#### **8.4.3. Diagnostic assessment report**

Following the completion of the Diagnostic Assessment, a clinical formulation and recommendations for treatment shall be incorporated into a Diagnostic Assessment report. A Diagnostic Assessment report shall identify client strengths as well as barriers to be addressed during treatment in order to reduce or eliminate identified deficits. The report shall include Diagnoses on all five (5) axis of the DSM-IV, and document the client's participation in the assessment process.

An LPHA shall complete the Diagnostic Assessment report no later than five (5) business days after the completion of the Diagnostic/Assessment.

### **8.5. Master Treatment Plan Development And Implementation**

The Master Treatment Plan (MTP) shall serve as the order for MHRS and other services and certify that those services are medically necessary as indicated by the LPHA's signature on the initial and subsequent MTP.

#### **8.5.1. Core Provider responsibility.**

Each Core Provider shall develop and maintain a complete and current MTP for each enrolled MHRS consumer.

**8.5.2. Timeline For Development.**

The initial Master Treatment Plan shall be developed concurrently with the Diagnostic Assessment Report.

**8.5.3. Minimum MTP Components.**

At a minimum, a Master Treatment Plan outlines the goals identified by the client, the corresponding treatment goals and objectives that can be delivered by the Core Provider and/or Specialty Provider through MHRS and other DMHAS services, and an “order” for an amount, frequency and duration of specific DMHAS and MHRS services in order to address the issues identified within the Diagnostic Assessment. The name of the provider – either the Core Provider or Specialty Provider – will be identified for each MHRS service specified on the MTP.

**8.5.4. Relationship to Client’s Recovery Plan.**

A Master Treatment Plan is only one-part of a client’s recovery plan; it is expected that clients will have their own recovery goals and plans in addition to those funded through DMHAS and MHRS services.

**8.5.5. Documentation Of Client Participation.**

Specific information describing the consumer’s response to, participation in and agreement to the MTP shall be recorded in the client’s clinical record.

**8.5.6. Policy.**

Each Core MHRS provider shall develop policies and procedures for MTP development and review (MTP Development and Review Policy).

**8.5.7. Review and Update of MTP.**

The MTP must be reviewed and updated every ninety (90) days and any time there is a significant change in the client’s condition or situation that would require a change in level of care, medically necessary services, or long- and mid-term goals. The MTP may be reviewed more frequently, as necessary, based on the consumer’s progress or circumstances.

**8.5.8. Master Treatment Plans for Clients Enrolled in ACT.**

Once a client is enrolled in an ACT-team, the ACT team has responsibility for reviewing and updating the Master Treatment Plan.

**8.6. Recovery Plan Development and Implementation**

**8.6.1. Definition**

Each client’s Recovery Plan shall consist of their Master Treatment Plan and a Rehabilitation Plan that includes details about service-specific objectives, interventions, and plans that support the attainment of the MTP goals, and anything

else the client incorporates to support their recovery. Core providers that are delivering all the MHRS may choose to have a single, integrated document with all levels of detail incorporated into that plan. In that case, the MTP and the Rehabilitation Plan may be the same document. In cases where a client has chosen to receive services from multiple providers, the Recovery Plan may be comprised of several interlocking documents.

#### **8.6.2. Timeline**

In all cases, a written Rehabilitation Plan with specific objectives, interventions, and providers, shall be developed in conjunction with the client within 30-days of referral to an ACT team, a Community Support Team, or a residential rehabilitation group home. All providers of services outlined on the MTP shall maintain current copies of all sections of the client's Rehabilitation Plan, as well as the MTP and most recent Diagnostic Assessment.

## **9. DOCUMENTATION REQUIREMENTS**

### **9.1. Medical records**

A client service record shall be maintained and shall include, at a minimum: identifying information; social and health history; the reason for admission to the MHRS program; copies of the most current Diagnostic Assessment report; copies of the initial and all subsequent orders for MHRS services as documented on the Master Treatment Plan; initial and all subsequent service-specific rehabilitation plans (if separate from the MTP); identification of the care and services provided; a current list of all medications; and the plan for discharge and disposition of the MHRS client.

### **9.2. Encounter Notes**

Encounter notes shall be maintained for each rehabilitative service provided. The notes shall include the:

- Service rendered (Residential Rehabilitation, ACT, Community Support Team),
- Actual time the service was rendered (start and stop time)
- Location of service,
- The goal and objective that is the focus of the intervention,
- A general description of the content of the intervention to provide evidence that it is a rehabilitative service (as described in section 17b-262-763 of the Regulations of Connecticut State Agencies) and that is in compliance with the service definition, and
- The client's response to the intervention.
- Encounter notes shall be signed, dated and indicate the credentials of the staff member who provided the service.

### **9.3. Monthly Progress Notes**

At least monthly a progress note shall be prepared that describes the interventions the client has received over the past month, the client's overall response, and the client's specific progress toward the goals and objectives listed on the rehabilitation plan. The note shall be signed or co-signed by the licensed clinician for ACT and Community

Support Team; or by the Program Director and/or Licensed clinician for Residential Rehabilitation. The note shall discuss any variance between the services listed on the Master Treatment Plan and/or rehabilitation plan and the services actually delivered. The note shall also discuss any suggested changes, if any, to the Master Treatment Plan and/or the rehabilitation plan. Monthly Progress Notes shall be transmitted to Core Providers when the service is delivered by a Specialty Provider.

## **10. ASSERTIVE COMMUNITY TREATMENT SERVICE REQUIREMENTS**

### **10.1. Description & Goals of Service**

Assertive Community Treatment (ACT) is a recovery focused, high intensity, community based service for individuals discharged from multiple or extended stays in hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated and rehabilitative community support, crisis, and treatment interventions/services that are available 24-hours/7days a week.

ACT must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings.

The ACT team provides nearly all the treatment and works collaboratively as a team with blended roles and not as a group of individual practitioners who operate with primary responsibilities of their own.

ACT community and clinical services are guided by the consumers' strengths and preferences, an assertive approach, individual tailored programming, ongoing monitoring, variable support, in vivo service, relating to consumers as responsible citizens, direct availability twenty-four (24) hours per day, utilizing a variety of community resources and collaborating with the family.

The working philosophy of ACT is an assertive "can do" approach, with "in-vivo" service provision based in the community. Community-based treatment allows the team to be intimately familiar with the consumer's surroundings, strengths and challenges and assists the consumer in developing treatment strategies and learning opportunities for successful community living. The team is persistent in engagement, doing whatever it needs to do to keep the consumer engaged with the community and in treatment.

### **10.2. Included Interventions**

Within medical necessity and in direct response to assisting the individual to reduce the effects of their psychiatric and restore their functioning to its best possible level, interventions include:

- Comprehensive Assessment, including psychiatric history, mental status, and diagnosis; physical health; use of drugs and alcohol; education and employment; social development and functioning; activities of daily living; family structure and relationships; and environmental supports.

- Treatment Planning, including Master Treatment Planning after the initial referral to the team.
- Service Coordination within the team.
- Crisis Assessment and Intervention.
- Symptom Assessment and Management, and teaching of self-assessment and management skills.
- Medication Prescription, Administration, Monitoring and Education
- Counseling and psychotherapy.
- Dual diagnosis substance abuse services.
- Work- and Education-Related Services, inclusive of Medicaid-reimbursed and Non-Reimbursable services.
- Residential Supports to assist individuals with gaining capacity to live in the community.
- Assisting individuals' with gaining increased functioning to manage their activities of daily living
- Social/Interpersonal Relationship and Leisure-Time Skill Training
- Peer Support Services
- Environmental and other supports
- Education, support and consultation to clients' families and other major supports.

**10.3. Program Requirements.**

**10.3.1.** ACT must be delivered by a Certified Core MHRS Provider.

**10.3.2.** Program operates at least 12 hours per day Monday through Friday. Provides at least 8 hours of direct service each weekend day or holiday. Team member must be on call for all other hours. ACT team members are expected to provide the primary point of coordination for crisis response to ACT recipients; crisis services will be provided in conjunction with the local mental health authority's emergency services program as appropriate.

**10.3.3.** 60% of all staff contacts must be face-to-face with the ACT clients. Remaining time may be phone or collateral. At least 75% of all team contacts occur out of the office. On average, at least three face-to face contacts per week are provided for ACT clients.

**10.3.4.** Services may be delivered by a single team member to two ACT clients at the same time if their goals are compatible; however, this cannot be standard practice. Services cannot be offered by a single individual to more than two individuals at a time (exception below). The only scenario in which ACT may be offered to more than two people is when a curriculum-based therapeutic group is offered (such as DBT, Trauma, IDDT groups). For this to be allowable, there must be an identified cohort of ACT participants whose clinical needs and recovery goals justify intervention by staff trained in the implementation of a specific curriculum-based method. The group may be offered to no more than eight ACT participants at one time and must be directed by no fewer than two

ACT staff in order to be billed as ACT. This may be offered no more than two hours in any given week.

- 10.3.5.** Each consumer within an ACT team will have a designated, primary staff member as a central point of contact and coordination.

**10.4. Staffing Requirements**

- 10.4.1.** The minimum size for an ACT team is 5 FTE (excluding the psychiatrist).

All teams are required to have, at a minimum:

10.4.1.1. Full-time team leader who is the clinical and administrative supervisor of the team and who also functions as an ACT clinician. Minimum requirements are for a Licensed Clinician (see definitions at end.)

10.4.1.2. A psychiatrist who works on a full- or part-time basis for a minimum of 8 hours per week for every 25 individuals. The psychiatrist must provide clinical and crisis services to all team service recipients, work with the team leader to monitor each individual's clinical and medical status and response to treatment, and direct psychopharmacologic and medical treatment. (If the team nurse is an APRN certified to diagnose and prescribe, the APRN may cover for up to half the prescribed psychiatrist time.)

10.4.1.3. A full-time registered nurse, with a minimum of a bachelor's degree in nursing providing nursing services for all ACT team service recipients and who works with the ACT team to monitor each consumer's clinical status and response to treatment. Functions as a primary practitioner on the ACT team for a caseload of consumers.

10.4.1.4. A clinically trained general practitioner who is either master's prepared or a Licensed Clinician who provides individual and group support to team service recipients and functions as a primary practitioner on the team for a caseload of consumers. (This position is in addition to the Team Leader.)

10.4.1.5. Two recovery specialists, either paraprofessionals or professionals, who work under the supervision of a licensed professional and function as primary practitioners for a caseload of consumers and who provide rehabilitation and support functions

10.4.1.6. One FTE program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individuals.

10.4.1.7. At least one of the members of the core team must have special training and/or certification in substance abuse treatment and/or treating persons with co-occurring disorders.

10.4.1.8. At least one member of the team should be a consumer in recovery who has been specially credentialed based on their psychiatric and life experiences. (This process is being developed, and the Consumer advisory Task Force recommends that at least two peer recovery specialists work together)

10.4.1.9. At least one member of the core team must have special training in rehabilitation counseling, especially vocational, work readiness, and educational support.

10.4.2. Each team is expected to maintain a staff to client ratio of no more than 1 staff person per 10 clients (excluding the psychiatrist and program assistant).

10.4.3. Teams that serve more than 50 clients must first add staff to achieve a minimum of 1 FTE each in the following specialties before adding more generalist recovery specialists:

- Co-occurring treatment
- Rehabilitation (work and education readiness)
- A consumer in recovery.

10.4.4. ACT teams are encouraged to incorporate specialty clinical expertise in trauma counseling and response.

## 10.5. Excluded Services.

10.5.1. An individual may receive ACT services from only one ACT provider at a time.

10.5.2. ACT is a comprehensive team intervention and most other Medicaid, DMHAS, and SAGA services are excluded. However, Opioid Treatment can be provided concurrently with ACT.

10.5.3. Individuals receiving any of the following services are excluded from ACT:

- Residential rehabilitation services in a group home
- Community Support Team ( unless used as a transition as defined in 12.5)

10.5.4. On an individual basis and as reflected in the treatment plan, individuals may receive a limited amount of specialty services such as trauma and IOP if these services are not available within the ACT team.

10.5.5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance-related disorder.

## 11. COMMUNITY SUPPORT TEAM SERVICE REQUIREMENTS

### 11.1. Description & Goals of Service

Community Support Team services consist of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining rehabilitative, sobriety and recovery goals. The service is designed to meet the mental health/substance abuse treatment, financial, social, educational, vocational, residential, and other treatment support needs of the individual. Services and interventions are highly individualized and tailored to the need and preferences of the individual, with the goal of maximizing independence and supporting recovery.

Community Support provides an array of services delivered by community-based, mobile, multidisciplinary teams of professionals, trained others, and peer specialists. Services may be delivered individually or in groups no larger than 8 individuals. The services focus on building and maintaining a therapeutic relationship with the individual and emphasize:

- Assisting the individual to have hope for and participate in his or her own recovery and independence.
- Helping the individual identify needs, strengths, skills, resources, and supports related to attainment of independence. Helping the individual use available skills, resources, and supports to achieve independence;
- Helping the individual to identify and achieve their personalized recovery; and
- Promoting an individual's responsibility and skills related to illness self-management.

Community Support services are intended for individuals whose mental health needs require active assistance and support to function independently in community settings or to maintain their life in a community setting.

#### **11.2. Inclusion Interventions**

- Support to facilitate recovery (including support and assistance with defining what recovery means to the individual in order to assist the individual with recovery-based goal setting and attainment). For those who have achieved a level of recovery stability, assistance and support to prevent relapse. Assistance in identifying, with individual, risk factors related to psychiatric and/or substance-abuse disorder relapse and strategies to prevent relapse.
- Participation in the development and implementation of an individual's treatment plan which supports recovery.
- Assistance and support for the individual in crisis situations; coordination and/or assistance with crisis providers as needed.
- Education, support and consultation to individual's families and their support system which is directed exclusively to the well being and benefit of the individual.
- Individualized, restorative interventions to develop interpersonal/social, community coping, and independent living/functional skills (including adaptation to home, school, work and community environments)
- Assistance in the acquisition of self-monitoring and management skills related to symptoms and illness (for example, medication self-monitoring and assistance in the development of self-medication skills; coping skills; or help-seeking behaviors) in order to identify and minimize the negative effects of symptoms which interfere with individual's daily living.
- Assistance in increasing social support skills and networks that ameliorate life stresses resulting from the individual's disability and which are necessary to maintain the individual's independent living.
- Assisting the individual to gain access to necessary rehabilitative services, medical services, general entitlement benefits, wellness, or other services. Assisting the individual to gain skills in accessing needed services and using them beneficially.

#### **11.3. Program Requirements.**

- 11.3.1.** Community support may be delivered by a DMHAS-certified MHRS Core Provider agency or by a DMHAS-certified MHRS Specialty Provider with an Affiliation Agreement with a Core Provider.
  - 11.3.2.** Face-to-face Community Support occurs during times and locations that reasonably accommodate the individual's needs for services in community locations and other natural settings, and at hours that do not interfere with the individual's work, educational, and other community activities.
  - 11.3.3.** 60% of all billable community support contacts must be face-to-face with the individual.
  - 11.3.4.** At least 60% of all community support services must be outside of the agency, in community settings.
  - 11.3.5.** All individuals receiving community support services must receive a minimum of two face-to-face contacts in a 90-day period.
  - 11.3.6.** In most cases, Community Support Team may only be billed by a single provider for a given client. In cases where Community Support Team is delivered by a Specialty Provider, the MHRS Core Provider may bill up to xx units of Community Support Team each treatment plan period for development, evaluation and revision of the Master Treatment Plan. (The service numbers will be developed in the Clinical Management Workgroup)
- 11.4. Staffing Requirements.**
- 11.4.1.** Community Support services are provided by a team of staff that is responsible for an assigned group of individuals.
  - 11.4.2.** Each individual must have a clearly identified primary community support staff member who is responsible for coordinating and monitoring the treatment plan with the individual, the community support team, and with other providers.
  - 11.4.3.** Services are delivered under the supervision of a licensed professional (see definitions at end) who may be the team leader or a member of the team.
  - 11.4.4.** Clinical supervision shall occur at least monthly as evidenced by the supervisor's signature on a monthly progress note documenting the individual's progress toward meeting treatment plan goals and objectives.
  - 11.4.5.** Each team shall have a team leader who provides ongoing supervision. The team leader must have the following qualifications:
    - A licensed or licensed-eligible mental health professional (see definitions at end);
    - A person with a Master's degree in a behavioral health area and two years of mental health experience;
    - A person with a Master's degree in a behavioral health area and certification for USPRA; OR
    - A person with a Master's degree in a behavioral health area and a CADC.
  - 11.4.6.** Community support staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years experience in the provision of mental health

services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist.

**11.5. Excluded Services.**

ACT, Residential Rehabilitation in a MH Group Home, or Targeted Case Management may not be provided under the same treatment plan as Community Support Team. However, Community Support Team Services can be billed for a limited period of time in accordance with a treatment plan for individuals who are receiving ACT or residential rehabilitation in a MH Group Home for the purpose of facilitating transition to the service, admission to the service, meeting with the individual as soon as possible upon admission, and providing coordination during the provision of service.

**12. RESIDENTIAL REHABILITATION IN A MENTAL HEALTH GROUP HOME SERVICE REQUIREMENTS**

(To be added later. Not applicable for interim process.)

**13. NON-REIMBURSABLE SERVICES**

Services not covered as MHRS include, but are not limited to:

- Room and board residential costs;
- Transportation services;
- Vocational services;
- Socialization services;
- Prevention services;
- Watchful oversight;
- Educational services;
- Services which are not medically necessary;
- Services which are not provided and documented in accordance with these certification standards;
- Services which are not mental health services; and
- Services furnished to persons other than the consumer when those services are not directed primarily to the wellbeing of the consumer.

These services may be reimbursed through a contract with DMHAS or other funders under other programs.

## APPENDIX A: DEFINITIONS

The following terms have the meaning ascribed in this section:

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| Adult                     | A person who is 18 years of age or older;  |
| Affiliation agreement     | An agreement in the form approved by DMHAS by and between a Core Provider and a Specialty Provider that describes how they will work together to benefit consumers.  |
| Certification             | The written authorization from DMHAS rendering an entity eligible to provide MHRS. DMHAS grants certification to community-based organizations that submit an approved certification application and satisfy the certification standards.  |
| Certification application | The application and supporting materials prepared and submitted to DMHAS by a community-based organization requesting certification to provide MHRS.   |
| Certification standards   | The minimum requirements established by DMHAS in this Chapter that an MHRS provider shall satisfy to obtain and maintain certification to provide MHRS and receive reimbursement from DMHAS for MHRS   |
| Community Support Team    | Rehabilitation and environmental supports considered essential to assist a consumer in achieving rehabilitation and recovery goals.  |
| Core MHRS Provider        | <ul style="list-style-type: none"> <li>• Core Providers serve as the clinical home for all clients involved in MHRS. At a minimum, Core providers must: <ul style="list-style-type: none"> <li>○ Have active accreditation by a national accrediting body, including JCAHO, CARF or COA.</li> <li>○ On staff, have the direct capacity to provide the following clinical services to clients: <ul style="list-style-type: none"> <li>○ Diagnosis by a Licensed Practitioner of the Healing Arts (LPHA)</li> <li>○ Comprehensive Assessment, including biopsychosocial, psychiatric, addictions, and functional abilities</li> <li>○ Master treatment planning (Based on the diagnosis and comprehensive assessment, establishing – with the client – broad recovery goals and the services required to achieve those goals. For those services that are Medicaid funded, establishing medical necessity.)</li> <li>○ Master treatment plan coordination, monitoring, review and updating in coordination with all providers delivering service and in accordance with the client's recovery goals.</li> <li>○ Psychiatric medication assessment, prescription, and ongoing medication management.</li> </ul> </li> </ul> </li> </ul> |

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|                           | <ul style="list-style-type: none"> <li>○ Counseling and/or psychotherapy.</li> <li>○ Community Support Team.</li> <li>○ -Must offer, either directly or through contract, access to a clinician for review of any crisis on a 24 hour, 7-day a week, and 365-day a year basis to enrolled clients. For ACT clients, there must be an alert system developed to notify on-call ACT staff that a client may require special services.</li> <li>● Be a participating Medicaid provider in good standing in the State of Connecticut.</li> <li>● Meet timelines for treatment planning and review (and all other requirements, including clinical management/utilization management) of all enrolled clients, both for services provided internally and through specialty providers with which the Core Provider has an affiliation agreement.</li> <li>● Enter into affiliation agreements with specialty providers delivering MHRS services and ensure that coordination of care and ongoing clinical communication is maintained to meet the needs of those clients.</li> <li>● Ensure that all MHRS clients receiving treatment from the Core Provider shall have a primary contact person from the Core Provider's staff. In cases where the client is receiving Community Support Team or ACT services from the Core Provider, the primary contact person shall be the client's primary contact on the team. In cases where there are multiple services offered, the primary contact person shall be part of the client's treatment team at the Core Provider.</li> <li>● Maintain listings, in a manner determined by DMHAS, of all current enrolled clients, along with each client's primary contact with the Core agency, and any specialty providers delivering mental health services to each client.</li> </ul> |
| Corporate Compliance Plan | A written plan developed by each MHRS provider to ensure that the MHRS provider operates in compliance with all applicable federal and Connecticut laws and regulations.   |
| Credentialed staff        | Unlicensed staff or staff who are not licensed clinicians who are credentialed by the MHRS provider to perform certain MHRS or components of MHRS under the clinical supervision of a licensed clinician.  |
| Cultural competence       | Includes a system of policies, skills and attitudes that enable an agency or program to provide client services in a manner that effectively responds to differences in cultural beliefs, behaviors and learning and communication styles.   |
| DSS                       | Department of Social Services  |
| Diagnostic/Assessment     | Intensive clinical and functional evaluation of a consumer's mental health condition that results in the issuance of a Diagnostic/Assessment report with recommendations for service delivery; May serve as the initial Master Treatment Plan by ordering  |

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|  | MHRS services.  |
| Diagnostic/Assessment report                       | The report that summarizes the results of the Diagnostic/Assessment and includes recommendations for service delivery.  |
| DMHAS  | Department of Mental Health and Addiction Services or its agent;  |
| DPH  | Department of Public Health;  |
| Encounter Note                                     | <p>A note that documents billable encounters with the client. Each note shall include the:</p> <ul style="list-style-type: none"> <li>• service rendered (Residential Rehabilitation, ACT, Community Support Team),</li> <li>• actual time the service was rendered (start and stop time)</li> <li>• location of service,</li> <li>• the goal and objective that is the focus of the intervention,</li> <li>• a general description of the content of the intervention to provide evidence that it is a rehabilitative service (as described in section 17b-262-763 of the Regulations of Connecticut State Agencies) and that is in compliance with the service definition, and</li> <li>• The client's response to the intervention.</li> <li>• Encounter notes shall be signed, dated and indicate the credentials of the staff member who provided the service.</li> </ul>  |
| Governing authority                                | The designated individuals or governing body legally responsible for conducting the affairs of the MHRS provider.   |
| Grievance  | A description by any individual of his or her dissatisfaction with an MHRS provider, including the denial or abuse of any consumer right or protection provided by applicable federal and Connecticut laws and regulations.   |
| Human Services Contract                            | The written agreement entered into by the DMHAS-certified MHRS provider and DMHAS which describes how the parties will work together.   |
| Licensed clinician and Licensed Eligible Clinician | <ul style="list-style-type: none"> <li>• a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;</li> <li>• a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;</li> <li>• a marriage and family therapist who is licensed under chapter 383a of the Connecticut General Statutes;</li> <li>• a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes; or who is receiving the supervision necessary to obtain the licensure</li> <li>• an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;</li> <li>• a registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field; or</li> <li>• a professional counselor who is licensed under chapter 383c of</li> </ul> |

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|  | the Connecticut General Statutes; or is receiving the supervision necessary to obtain a license.   |
| Licensed Practitioner of the Healing Arts (LPHA) | <ul style="list-style-type: none"> <li>• a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;</li> <li>• a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;</li> <li>• an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;</li> <li>• a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;</li> </ul>  |
| Master Treatment Plan                            | A treatment plan, based on a diagnostic assessment, that outlines medically necessary goals and services that assist a client with meeting their recovery goals. Serves as an order for MHRS services and directs the care of all ordered services.  |
| Medicaid   | The program operated by DSS pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;  |
| Medically necessary                              | Those health care services contained in a treatment and/or rehabilitation plan provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring;  |
| Mental Health Rehabilitation Services or MHRS    | Mental health rehabilitative or palliative services provided by a DMHAS-certified mental health provider to clients in accordance with the Connecticut State Medicaid Plan, the DSS/DMHAS Interagency Agreement, and this chapter.   |
| Mental illness                                   | A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.   |
| MHRS provider                                    | An organization certified by DMHAS to provide MHRS. MHRS providers include Core Providers and Specialty Providers.   |
| Monthly Progress Note                            | At least monthly a progress note shall be prepared that describes the interventions the client has received over the past month, the client's overall response, and the client's specific progress toward the goals and objectives listed on the rehabilitation plan. The note shall be signed or co-signed by the licensed clinician for ACT and Community Support Team; or by the Program Director and/or Licensed clinician for Residential Rehabilitation. The note shall discuss any variance between the services listed on the Master Treatment Plan and/or rehabilitation plan and the services actually delivered. The note shall also discuss any suggested changes, if any, to the Master Treatment Plan and/or the rehabilitation plan. Monthly Progress Notes shall be transmitted to Core Providers when the service is delivered by a Specialty Provider. |

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| 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.  |
| Provider               | An organizational entity that participates in the Medicaid program as a provider of adult rehabilitative services and certified by DMHAS as an MHR provider.  |
| Policy                 | A written statement developed by an MHR provider that gives specific direction regarding how the MHR provider shall operate administratively and programmatically.  |
| Procedure              | A written set of instructions describing the step-by-step actions to be taken by MHR provider staff in implementing a policy of the MHR provider.   |
| Recovery Plan          | A client's comprehensive plan for achieving personal recovery goals. May incorporate services to be accessed through DMHAS including a Master Treatment Plan and a Rehabilitation Plan as well as personal, educational, spiritual, vocational, and other goals and services to be accessed by the individual independently of DMHAS providers. |
| Rehabilitation Plan    | A plan that spells out the specific objectives delivered under the MHR to assist a client with meeting their recovery goals and the Master Treatment Plan goals.  |
| Specialty MHR Provider | a community-based organization MHR provider certified by DMHAS to provide Community Support Team OR Residential Rehabilitation in a Group Home services to clients who are also being served by a Core Provider. Each specialty provider shall enter into an affiliation agreement with DMHAS-certified Core Providers serving shared clients.  |
| Under the supervision  | Means that a licensed clinician provides supervision of the work performed by unlicensed clinical staff and accepts primary responsibility for the rehabilitative services performed by the unlicensed staff.   |

## **APPENDIX B: MHRS PROVIDER QUALIFICATIONS FOR NON-ACCREDITED PROVIDERS**

1. A Medical Records Administrator, responsible for:
  - Ongoing quality control of clinical documentation;
  - Assuring that clinical records are maintained, completed, and preserved in accordance with the MHRS provider's Clinical Records Policy;
  - Assuring that information on enrolled consumers is immediately retrievable;
  - Establishing a central records index for the MHRS Core provider; and
  - Maintaining clinical documentation communications with affiliated Specialty providers on shared clients.
  
2. Credentialing Policy & Procedure
  - 2.1. Each certified MHRS specialty provider shall have an internal credentialing policy and procedure that details how the provider insures that staff delivering MHRS services:
    - Are qualified to deliver rehabilitation services through education, experience, and internal training
    - Are either licensed clinicians or are supervised by licensed clinicians, and.
    - Are subject to internal quality and compliance review.
  
  - 2.2. Each MHRS specialty provider shall establish and adhere to policies and procedures governing the credentialing of staff (Credentialing Policy) consistent with DMHAS rules on credentialing and competency-based credentialing systems. The Credentialing Policy shall:
    - Allow staff who do not possess college degrees to be credentialed for direct service work, based on educational equivalent qualifications which include experience that provides an individual with an understanding of mental illness and which was acquired as an adult through personal experience with the mental health treatment system and recovery or through the provision of significant supports to adults with mental illness or children and youth with mental health problems and with serious emotional disturbance;
    - Facilitate the employment of persons in recovery as peer counselors and members of community support teams; and
    - Include an assessment of all staff members' cultural competence.
  
3. Each MHRS provider shall be established as a legally recognized entity in the United States and qualified to conduct business in Connecticut.
4. Each MHRS provider shall maintain the clinical operations policies and procedures described in this section which shall be reviewed and approved by DMHAS, during the certification survey process.

5. Each MHRS provider shall:
  - a) Have a governing authority, which shall have overall responsibility for the functioning of the MHRS provider;
  - b) Comply with all applicable federal and Connecticut laws and regulations;
  - c) Hire personnel with the qualifications necessary to provide MHRS and to meet the needs of its enrolled consumers;
  - d) Ensure that licensed clinicians are available to provide appropriate and adequate supervision of all clinical activities; and
  - e) Employ licensed clinicians that meet all professional requirements as defined by Connecticut's licensing laws and regulations relating to the profession of the licensed clinician.
  
6. Each MHRS provider shall establish and adhere to policies and procedures for selecting and hiring staff (Staff Selection Policy), including, but not limited to requiring:
  - a) Evidence of licensure, certification or registration as applicable and as required by the job being performed;
  - b) For unlicensed staff, evidence of completion of an appropriate degree, training program, or credentials, such as academic transcripts or a copy of degree, as designated by the provider's own policies and procedures and in accordance with MHRS service requirements;
  - c) Appropriate reference and background checks, including primary source verification of all licenses and degrees;;
  - d) Evidence of completion of all communicable disease testing required by Connecticut laws and regulations,
  - e) A process by which all staff, as a condition of hiring, shall:
    - i) Declare any past events which might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations;
    - ii) Indicate whether they are presently using illegal drugs; and
    - iii) Attest that they are capable of performing the essential functions of their jobs, with or without accommodation; and
  - f) A mechanism for ongoing monitoring of staff licensure, certification, or registration, such as an annual confirmation process concurrent with staff performance evaluations which includes repeats of screening checks outlined above as appropriate.

7. Each MHRS provider shall establish and adhere to written job descriptions for all positions, including, at a minimum, the role, responsibilities, reporting relationships, and minimum qualifications for each position. The minimum qualifications for each position shall be appropriate for the scope of responsibility and clinical practice described for each position.
8. Each MHRS provider shall establish and adhere to policies and procedures requiring a periodic evaluation of clinical and administrative staff performance (Performance Review Policy) that require an assessment of clinical competence, as well as general organizational work requirements, and an assessment of key functions as described in the job description.
9. Each MHRS provider shall provide training to all staff, including all licensed clinicians (both those employed and those under contract to the MHRS provider), an orientation to MHRS (Staff Orientation Training) prior to delivering any MHRS services and on an ongoing basis. The Staff Orientation Training curriculum shall at a minimum address the following:
  - a) Mental illnesses and evidence-based clinical interventions;
  - b) Consumer rights;
  - c) Declaration of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives;
  - d) Definitions and types of abuse and neglect and the MHRS provider's policies on investigating allegations of abuse and neglect;
  - e) Recovery model, psychiatric rehabilitation, consumer and family empowerment, and self-help or peer support;
  - f) Knowledge of medication, its benefits, and side effects;
  - g) Communication skills;
  - h) Integrated treatment for co-occurring psychiatric and addictive disorders;
  - i) Behavior management;
  - j) Handling emergency situations;
  - k) Recordkeeping and clinical documentation standards;
  - l) Confidentiality;
  - m) MHRS provider's policies and procedures;
  - n) Medicaid MHRS requirements, especially those relating to recordkeeping, billing, documentation, and consumer choice; and
  - o) Cultural competence and its relationship to treatment outcomes.
10. Each MHRS provider shall establish and adhere to an annual training plan for staff to ensure that all staff receive at a minimum, annual training on the following topics (Annual Training Plan):
  - a) The subjects covered during Staff Orientation Training;
  - b) Infection control guidelines, including compliance with the blood borne pathogens standard, communicable diseases and universal precautions; and

**c) Safety and risk management.**

**11.** Each MHRS provider shall establish and adhere to policies and procedures for handling routine, urgent, and emergency situations. This policy shall:

- d)** Include referral procedures to local emergency departments;
- e)** Include staff assignment to cover emergency walk-in hours;
- f)** Include on-call arrangements for clinical staff and physicians;
- g)** Cover the interface with the DMHAS-designated crisis and emergency service; and
- h)** Include procedures for triaging consumers who require Crisis/Emergency services or psychiatric hospitalization.

**12.** Each MHRS provider shall establish and adhere to policies and procedures for clinical record documentation, security, and confidentiality of consumer and family information, clinical records retention, maintenance, purging and destruction, and for disclosure of consumer and family information, and informed consent that comply with applicable federal and Connecticut laws and regulations (Clinical Records Policy). The Clinical Records Policy shall:

**12.1.** Require the MHRS provider to maintain all clinical records in a secured and locked storage area;

**12.2.** Require the MHRS provider to maintain and secure a current, clear, organized, and comprehensive clinical record for every individual assessed, treated, or served which includes information deemed necessary to provide treatment, protect the MHRS provider, or comply with applicable federal and Connecticut laws and regulations; and

**12.3.** Require that the clinical record contain information to identify the consumer, support the diagnosis, justify the treatment, document the course and results of treatment, and facilitate continuity of care. The clinical record shall include, at a minimum:

- i)** Consumer identification information, including enrollment information;
- ii)** Identification of a person to be contacted in the event of emergency;
- iii)** Basic screening and intake information;
- iv)** Documentation of internal or external referrals;
- v)** Comprehensive diagnostic and psychosocial assessments;
- vi)** Pertinent medical information including the name, address, and telephone number of the consumer's primary care physician and the name and address of the consumer's preferred hospital;
- vii)** Advance instructions and advance directives;
- viii)** The Master Treatment Plan;
- ix)** Rehabilitation Plan(s) as appropriate;
- x)** Methods for addressing consumers' and families' special needs, especially those which relate to communication, cultural, and social factors;
- xi)** Detailed description of services provided;
- xii)** Encounter and Progress notes;
- xiii)** Discharge planning information;

- xiv)** Appropriate consents for service;
- xv)** Appropriate release of information forms; and
- xvi)** Signed Consumer Rights Statement.

**12.4.** Each MHRS provider shall ensure that all clinical records of consumers are completed promptly, filed, and retained in accordance with the MHRS provider's Clinical Records Policy.

- 13.** Each MHRS provider shall establish and adhere to policies and procedures requiring the MHRS provider to make language interpreters available as needed for persons who do not use English as a first language or use a non-primary language for communication (Interpreter Policy).
- 14.** Each MHRS provider shall establish and adhere to policies and procedures which govern the provision of services in natural settings (Natural Settings Policy). The Natural Settings Policy shall require the MHRS provider to document how it respects consumers' and families' right to privacy and confidentiality when services are provided in natural settings.
- 15.** Each MHRS provider shall establish and adhere to policies and procedures governing quality improvement (Quality Improvement Policy). The Quality Improvement Policy shall require the MHRS provider to adopt a written Quality Improvement (QI) plan describing the objectives and scope of its QI program and requiring MHRS provider staff, consumer, and family involvement in the QI program. DMHAS shall review and approve each MHRS provider's QI program, based on the standards determined by the DMHAS QMI Department.
- 16.** Each MHRS provider shall comply with the following requirements for management of facilities where client-services are delivered:
- a)** Each MHRS provider's service site(s) shall be located and designed to provide adequate and appropriate facilities for private, confidential individual and group sessions.
  - b)** Each MHRS provider's service site(s) shall have appropriate space for group activities and educational programs.
  - c)** All areas of the MHRS provider's service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.
  - d)** Each MHRS provider shall comply with applicable provisions of the Americans with Disabilities Act in all business locations.
  - e)** Each MHRS provider shall establish and adhere to a written evacuation plan to be used in fire, natural disaster, medical emergencies, bomb threats, terrorist attacks, violence in the work place, or other disaster for all service sites (Disaster Evacuation Plan).
  - f)** The Disaster Evacuation Plan shall require the MHRS provider:
    - i)** To conduct periodic disaster evacuation drills;
    - ii)** Ensure that all evacuation routes are clearly marked by lighted exit signs; and

- iii) Ensure that all staff participate in annual training about the Disaster Evacuation Plan and disaster response procedures.
  - g) Each MHRS provider shall obtain a written certificate of compliance indicating that all applicable fire and safety code requirements have been satisfied.
  - h) Each MHRS provider shall provide physical facilities for all service site(s) which are structurally sound and which meet all applicable federal and Connecticut laws and regulations for adequacy of construction, safety, sanitation and health.
  - i) Each MHRS provider shall establish and adhere to policies and procedures governing infection control (Infection Control Policy). The Infection Control Policy shall comply with applicable federal and Connecticut laws and regulations.
17. Each MHRS provider shall have established by-laws or other legal documentation regulating the conduct of its internal financial affairs. This documentation shall clearly identify the individual(s) that are legally responsible for making financial decisions for the MHRS provider and the scope of such decision making authority. Each MHRS provider shall:
- a) Maintain an accounting system that conforms to generally acceptable accounting principles, provides for adequate internal controls, permits, the development of an annual budget, an audit of all income received and an audit of all expenditures disbursed by the MHRS provider in the provision of services;
  - b) Have an internal process that allows for the development of interim and annual financial statements that compares actual income and expenditures with budgeted amounts, accounts receivable, and accounts payable information; and
  - c) Operate in accordance with an annual budget established by its governing authority.
18. Each MHRS provider shall establish and adhere to policies and procedures governing the retention, maintenance, purging and destruction of its business records (Records Retention Policy). The Records Retention Policy shall:
- a) Comply with applicable federal and Connecticut laws and regulations;
  - b) Require the MHRS provider to maintain all business records pertaining to costs, payments received and made, and services provided to consumers for a period of thirty (30) years or until all audits are completed, whichever is longer; and
  - c) Require the MHRS provider to allow DMHAS, DSS, the United States Department of Health and Human Services, and the Comptroller General of the United States or any of their authorized representatives to review the MHRS provider's business records, including clinical and financial records.
19. Each MHRS provider shall operate according to all applicable federal and Connecticut laws and regulations relating to fraud and abuse in health care, the provision of mental health services, and the Medicaid program. An MHRS provider's failure to report potential or suspected fraud or abuse may result in sanctions, cancellation of contract, or exclusion from participation as an MHRS provider. Each MHRS provider shall:
- a) Cooperate and assist the State and any federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud and abuse; and

- b)** Be responsible for promptly reporting suspected fraud and abuse to DMHAS, taking prompt corrective actions consistent with the terms of any contract or subcontract with DMHAS, and cooperating with DSS investigations.
- 20.** Each MHRS provider shall establish and adhere to a plan that contains policies and procedures for maintaining the security of data and information (Disaster Recovery Plan). Each MHRS provider's Disaster Recovery Plan shall also stipulate back-up and redundant systems and measures that are designed to prevent the loss of data and information and to enable the recovery of data and information lost due to disastrous events.

## APPENDIX C: QUALIFIED MHRS STAFF CREDENTIALS

| Service                       |   |
|-------------------------------|---|
| Diagnostic Assessment         | <p>LPHA:</p> <ul style="list-style-type: none"> <li>• Psychiatrist      • Psychologist</li> <li>• LCSW              • Advanced Practice Registered Nurse</li> </ul> <p>May diagnose</p>   |
| Master Treatment Plan         | <p>Must be signed by an LPHA:</p> <ul style="list-style-type: none"> <li>• Psychiatrist      • Psychologist</li> <li>• LCSW              • Advance Practice Registered Nurse</li> </ul> <p>• The consumer and all credentialed and licensed staff may contribute to the Master Treatment Plan.</p>  |
| Rehabilitation Plan           | <p>Licensed Clinician must sign the rehabilitation plan.</p>  |
| Community Support Team Leader | <ul style="list-style-type: none"> <li>• Licensed Clinician</li> <li>or</li> <li>• A person with a Master's degree in a behavioral health area and two years of mental health experience;</li> <li>or</li> <li>• A person with a Master's degree in a behavioral health area and certification for USPRA;</li> <li>or</li> <li>• A person with a Master's degree in a behavioral health area and a CADC.</li> </ul> |
| Community Support Staff       | <p>Under the supervision of a licensed clinician.</p> <ul style="list-style-type: none"> <li>• Any licensed clinician</li> <li>• Community support staff shall hold either a bachelor's degree in a behavioral health-related specialty OR</li> <li>• have two years experience in the provision of mental health services OR</li> <li>• Be a Certified Peer Specialist.</li> </ul>                                 |

| Service                    |   |
|----------------------------|---|
| ACT Team Leader            | <p>Licensed Clinicians:</p> <ul style="list-style-type: none"> <li>• a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;</li> <li>• a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;</li> <li>• a marriage and family therapist who is licensed under chapter 383a of the Connecticut General Statutes;</li> <li>• a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;</li> <li>• an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;</li> <li>• a registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field; or</li> <li>• a professional counselor who is licensed under chapter 383c of the Connecticut General Statutes;</li> </ul> |
| ACT                        | <ul style="list-style-type: none"> <li>• M.D. or D.O</li> </ul> <p>Under the supervision of a licensed clinician:</p> <ul style="list-style-type: none"> <li>• Any licensed clinician</li> <li>• Community support staff shall hold either a bachelor's degree in a behavioral health-related specialty OR</li> <li>• have two years experience in the provision of mental health services OR</li> <li>• Be a Certified Peer Specialist.</li> </ul>   |
| Residential Rehabilitation | <ul style="list-style-type: none"> <li>• Rehab Staff will participate in a minimum of monthly individual and/or group case conferences conducted by a Licensed Clinician (recommended) or the Program Director/Manager.</li> <li>• Rehab Staff will receive a minimum of quarterly individual and/or group supervision by a Licensed Clinician including review and co-signature of the 90 day service plan reviews.</li> </ul>   |
| Monthly Progress Note      | <ul style="list-style-type: none"> <li>• Signed by a licensed clinician (ACT &amp; Community Support) or</li> <li>• Program Director or Licensed Clinician (Residential Rehabilitation Group Homes)</li> </ul>  |
| Encounter Note             | <ul style="list-style-type: none"> <li>• Credentialed Staff delivering service</li> </ul>   |