The Standards are the structural components for achieving effective child specific rehabilitative service outcomes in support of restoring the child to the highest possible level of functioning and achieving the child specific discharge plan.

STANDARD CATEGORY: GENERAL INFORMATION DOCUMENTATION

Standard 1.

Child's Full Legal Name in Record

1.1 The child's full legal name [first name, middle name(s), and last or surname, without use of initials or nicknames] is entered in the case record on the face sheet

Standard 2.

Child's Sex Is Noted in Record

2.1 The child's sex [male or female] is entered in the case record on the face sheet

Standard 3.

Child's Date of Birth in Record

3.1 The child's date of birth is entered in the case record on the face sheet

Standard 4.

Child's LINK Person ID Number in Record

4.1 The child's DCF LINK Person Identification Number (*as opposed to the Case Identification Number*) is obtained and entered in the case record on the face sheet

Standard 5.

Child's Medicaid Number in Record

5.1 The child's CT Medicaid Number is obtained and entered in the case record on the face sheet

Standard 6.

Child's Admission Date in Record

6.1 The child's date of admission into the program is entered in the case record on the face sheet

Standard 7.

Child's Discharge Date in Record

7.1 The child's date of discharge from the program is entered in the case record on the face sheet once the child has been discharged.

STANDARD CATEGORY: AUTHORIZATION & EVALUATION DOCUMENTATION

Standard 8.

Child's Reason for Placement in Record

8.1 The reason for the placement of the child is entered in the case record on the face sheet.

8.2 The reason for placement must note the focal problem including the pre-placement condition(s) (For Example: psychiatric, behavioral, medical, etc. conditions) and circumstance(s) (For Example: family, social, etc. circumstances) specific to this child that necessitated the current placement.

Standard 9.

Child's Psychosocial History in Record

9.1 A psychosocial history of the child is created by the program for this admission and clearly documented in the case record. The psychosocial history includes at minimum a clearly labeled "Family History," "Social History" (including developmental history information), and "Medical/Health History"(including psychiatric/treatment history information).

9.2 The psychosocial history is represented in one integrating, separate document identified by the program as containing this history information.

9.3 The psychosocial history is completed within the first 30 days from admission.

Standard 10.

DCF/CTBHP Referral Materials in Record

10.1 A copy of the DCF/ Connecticut Behavioral Health Partnership (CTBHP) Child and Adolescent Needs Survey (CANS)* for the child is placed in the case record

10.2 A copy of the DCF/CTBHP Registration Form for this level of PNMI rehabilitative services is in the

case record

10.3 The DCF CANS requirement applies to placements occurring on or after 7/1/07. For admissions prior to 7/1/07, the existing DCF 469's or Central Placement Team (CPT) materials used at that time can be used to meet this requirement.

Standard 11.

DCF/CTBHP Referral Materials Contain the Written Recommendation of a Licensed Clinical Practitioner

11.1 The DCF/CTBHP referral packet placed into the case record contains a written recommendation identifying the need for PNMI rehabilitative services for this level of care

11.2 The written recommendation for the level of PNMI rehabilitative services is formally signed off by a referring PNMI eligible licensed clinical practitioner (either by hand or by e-signature).

11.3 The licensed clinical practitioner sign off must include their name and their license credentials (For example: LCSW, LMFT, Ph.D., etc)

Standard 12.

DCF Referral Packet Includes a Full Diagnosis

12.1 A copy of the DCF/CTBHP referral materials and/or Registration Form with a full DSM diagnosis is entered into the case record.

Note: If the date of admission was prior to 7/1/07, a full DSM diagnosis may be contained in any part of the DCF referral materials

Standard 13.

DCF/CTBHP Placement Authorization/Reauthorization Document(s) With Authorization Number are in the Record

13.1a Copy/copies of the DCF/CTBHP placement authorization/reauthorization document with a placement number, authorizing each day of placement beginning with the date of admission or 2/1/06, whichever is later, and continuing through the last day of placement is in the case record.

AND

13.1b For placements beginning prior to 2/1/06 the CPT placement authorization form and number is also in the record (Due to procedural changes implemented by the Department as of 2/1/06 providers will have different placement authorization documentation in their records for placements made prior to 2/1/06)

Note: Acceptable documentation includes either a copy of the authorization form mailed by the CTBHP, or a copy printed from the CTBHP web site.

STANDARD CATEGORY: TREATMENT PLANNING DOCUMENTATION

Note: Every treatment plan document, beginning with the initial treatment plan, must follow the same format.

Standard 14.

Initial Individual Treatment Plan. Licensed Clinical Practitioner (LCP) Approved Initial Treatment Plan is Implemented Upon Admission

14.1 There is an initial formal written treatment plan (day of admission plan) in the record

14.2 The initial treatment plan is completed (authorized) on or before the day of admission

14.3 The plan specifies which signature is that of the authorizing licensed clinical practitioner (LCP) employed by or under contract with the provider

14.4 The authorizing LCP must sign the plan

14.5 The authorizing LCP must hand write the date of sign off

14.6 The authorizing LCP must write his/her credentials after the signature

14.7 The authorizing LCP's name must be printed on the plan listing his/her name, credentials and agency title

The Initial Treatment plan must also comply with standards 18, 19, 20, and 21 below

For electronic records, consultation with the PNMI reviewer will be needed regarding authorization procedures.

*The approval of the Initial Treatment Plan by the licensed clinical practitioner confirms that the date of approval is also the date of implementation of the plan, unless there is additional signed documentation in the Initial Plan citing another implementation date. The implementation date may not predate the date of LCP authorization.

Standard 15.

30 Day Individual Treatment Plan (ITP). The Initial ITP Must be Reviewed, Amended to Include Assessments and Observations Since Admission, and Reauthorized by the LCP Within 30 days of Admission

15.1 There must be a "30 day" individual treatment plan (plan following the initial treatment plan) that has been developed utilizing the facility's assessments and observations of the client)

15.2 The "30 Day" individual treatment plan must be completed (authorized) within 30 days of admission

15.3 The "30 Day" individual treatment plan must specify which signature is that of the authorizing licensed clinical practitioner (LCP)

15.4 The authorizing LCP must sign the plan

15.5 The authorizing LCP must hand write the date of sign off

15.6 The authorizing LCP must write his/her credentials after the signature

15.7 The authorizing LCP's name must be printed on the plan listing their name, credentials and agency title

The 30 day Individual Treatment plan must comply with standards 17, 18, 19, 20, 21, and 24 below

*The approval of the Treatment Plan by the licensed clinical practitioner confirms that the date of approval is also the date of implementation of the plan, unless there is additional signed documentation in the Plan citing another implementation date

Standard 16

Every Treatment Plan is Reviewed, Reprinted (with amendments and updates), Signed, and Dated by a Licensed Clinical Practitioner Within Every 90 Days of Admission

16.1 There must be at a minimum an individual treatment plan (a separate stand alone document meeting all treatment plan requirements) for each quarter (90 day period counted from the date of admission**)**

16.2 Every individual treatment plan must specify which signature is that of the authorizing licensed clinical practitioner (LCP)

16.3 The authorizing LCP must sign every individual treatment plan

16.4 The authorizing LCP must hand write the date of sign off on the individual treatment plan (the date following the LCP signature is the date the signature was affixed to the document)

16.5 The authorizing LCP must hand write his/her credentials after the signature

16.6 The authorizing LCP's name must be printed on the plan listing their name, credentials and agency title

For electronic records consultation with the PNMI reviewer will be needed regarding authorization procedures.

Standard 17

Record Indicates that Treatment Plans are Developed in Conjunction with DCF, the Child, and the Child's Family if Possible

17.1a Each treatment plan, beginning with the 30 day treatment plan, must contain the signature of the DCF representative, the child and the child's family representative indicating that they participated in the development of the treatment plan.

AND

17.1b In cases where the child, the child's DCF representative or the child's family representative did not sign off on the plan, there must be documentation in the plan identifying the reasons why they did not sign the document.

17.2 The treatment plan must contain documentation of how the DCF representative, the child , and their family participated in the treatment plan development (For example: physically attended the treatment planning meeting; participated in the meeting by conference call; involved in a telephone discussion of the treatment plan prior to or subsequent to the treatment planning meeting, etc.) If the child or the family did not participate in the development of the treatment plan, the treatment plan must contain documentation explaining why.

17.3 The treatment plan must contain documentation that a copy of the treatment plan was provided to the DCF representative, the child and their family (when applicable)

17.4 Specific to the child, there must be documentation that the plan was presented in language appropriate to the child's level of functioning.

Standard 18

Record Indicates that Treatment Plans are Based on Evaluations and Diagnosis

18.1 The treatment plan must have documentation in the plan clearly linking each goal to a sourced diagnosis and associated symptom(s) that it is intended to address. The sourced diagnosis should identify the date and evaluator and/or the specific document that identifies the sourced diagnosis. Specific citations need not be made for each of the goal's associated objectives.

AND/OR

18.2 The treatment plan must have documentation linking each goal to a functional impairment and the comprehensive evaluation/assessment (date and document name) that has determined the individual's rehabilitation needs or functional impairments in daily living (For example: for each goal, citing the evaluation/assessment findings that it is based on). Specific citations need not be made for each of the goal's associated objectives.

Standard 19.

Every Treatment Plan Includes Specific Behavioral Health Goals and Objectives

19.1 The treatment plan, beginning with the initial plan, must clearly identify the specific goals and objectives to be addressed for the child.

19.2 Each goal must be presented as a global statement that clearly describes the anticipated improvement in the functional impairment it is intended to address (goals are generally longer term in nature). While more global, the goal should still have a clearly stated focus that identifies what is reasonably expected to be accomplished within the projected course of treatment by the provider of care. It is expected that the goal of effective treatment is that the client will improve, thus, effective treatment goals should not be so generalized as to offer no guidance or focus regarding how the treatment will proceed.

19.3 Each objective must be presented as a specific and measurable statement that supports the attainment of the associated goal (An objective is measurable when it clearly identifies what has to be attained for completion).

Standard 20.

Every Treatment Plan Identifies the Types of Services to be Provided to the Child; as well as the Facility Staff, or External Providers, who will be Providing Those Services

20.1 The treatment plan must identify the specific services to be provided for the child (For example: individual therapy, group therapy, psycho-educational group, residential staff individual counseling, milieu behavior modification intervention, guided group interaction, therapeutic recreation, structured skills development activities, medication management education group, medical issue specific education and counseling (for example: for diabetes management), etc.).

20.2 The identified specific services must be linked in the treatment plan directly to a specific objective or objectives.

20.3 The provider (name **or** role) of each specific service must be identified in the treatment plan

Standard 21.

Every Treatment Plan Identifies the Frequency and Duration of Services to be Provided

21.1 The treatment plan must identify the frequency per unit of time of the services to be provided (That is: how many service sessions are provided per day/week/month, etc.) PRN services such as crisis interventions, specific behavioral interventions, etc., may be included with the frequency of "PRN" or "As needed". Treatment Plan identified session frequencies are understood to be the minimum expectation.

21.2 The treatment plan must identify the per session duration of the services to be provided (That is: how long each service session lasts in minutes/hours, etc.) for those services for which a session duration can be quantified (for example "PRN" or "As needed" services may not have a specific session duration). Treatment Plan identified session durations are understood to be the minimum expectation.

21.3 The treatment plan must identify the per service duration for services that are time limited, in addition to the frequency and per session duration (For example: 9 weeks for an anger management psycho-education group that meets weekly in a single session for 50 minutes)

Standard 22.

The Individual Treatment Plan is Reviewed, and Reauthorized as Necessary and Appropriate (Signed, and Dated) by a Licensed Clinical Practitioner within each 90 Days of Admission.

22.1 An LCP must authorize each individual treatment plan as necessary and appropriate within each 90 days of admission (the authorization is completed before the end date of the 90 day time period beginning from the date of admission, but no earlier than 31 days prior to the end of that 90 day period.)

Standard 23.

At the Time of Each Treatment Plan Review (Beginning With the First 90 Day Plan), the Authorizing LCP Must Enter into the Record a Detailed Review of Progress Since The Previous ITP Review.

23.1 At the time of each Treatment Plan review, the LCP must enter into the case record a written detailed evaluation of progress for each specific goal and objective of the treatment plan since the previous review. (This is preferred on the treatment plan itself but may be in a separate document. If a separate document is employed to provide the detailed review of progress, the LCP must sign and date the separate review of progress within PNMI timelines for reauthorization of the treatment plan, as well as signing the treatment plan within the required timelines. This standard does not require that the LCP author the detailed review of progress.)

Standard 24.

The Child's Specific Individual Discharge Plan Must Be Addressed, Updated And Documented In The Treatment Plan Beginning With The 30 Day Plan And For Every Treatment Plan Thereafter

24.1 The discharge plan must be documented within the treatment plan, beginning with the 30 day from admission treatment plan.

24.2 The discharge plan must include the projected date of discharge

24.3 The discharge plan must include the projected caregiver at discharge.

24.4 The discharge plan must include the need for concurrent discharge planning, when applicable.

24.5 The discharge plan must include the projected services that will be needed upon discharge, when they can be identified.

24.6 The discharge plan must indicate if there are barriers to discharge, identify them, and note any steps to be taken to address these barriers, when applicable.

STANDARD CATEGORY: SERVICE DELIVERY & PROGRESS DOCUMENTATION

Standard 25.

Frequency and Duration of Service Delivery (for all services across all disciplines including but not limited to clinical, residential, and therapeutic recreation) as Documented in the Progress Notes are Consistent with Treatment Plan Requirements

25.1 The treatment plan must be in compliance with PNMI Standard requirements 20 and 21.

25.2 For every service noted in the treatment plan, there must be a per session/service unit progress note in the record for each time the service is provided

25.3 The frequency of the services provided must meet the minimum frequency specified for that service in the treatment plan.

25.4 The duration of the services provided must meet the minimum duration specified for that service in the treatment plan.

25.5 When services are not provided at the frequency specified in the plan, there must be documentation in the progress notes indicating why the service was not provided as required.

Standard 26.

Type of Service Delivered is Noted in the Progress Notes (For example: Individual Therapy, Family Therapy, Group Therapy, Therapeutic Recreation, Social Skills Coaching, Psychiatric Evaluation, etc.)

26.1 The progress note must indicate the specific type of service that was provided utilizing the same service types as noted in the treatment plan

26.2 The progress note must indicate the actual session duration of the service that is being documented.

26.3 The progress note must be entered into the case record within 30 days of the date the service was delivered, or scheduled to be delivered.

Standard 27.

Date of Service is Noted in the Progress Notes

27.1 The progress note must specify the date the service was provided

Standard 28.

The Printed Name, Dated Signature and Agency Title of the Staff Person Providing the Service is Noted in the Progress Notes

28.1 Each progress note must include the printed name, hand dated signature and agency title of the staff person who provided the service

Standard 29.

ITP Goals and Objectives Related to the Service are Noted in the Progress Notes (for all services across all disciplines including but not limited to clinical, residential, and therapeutic recreation)

29.1 Each progress note must specify the treatment plan goal and objective being addressed by the service provided during that session/period.

Standard 30.

Progress of Child Toward Goals and Objectives is Noted in the Progress Notes

30.1 The progress note must indicate the progress towards achieving the goal and objective addressed.

Standard 31.

Specific to Progress Notes Entered by the Residential Milieu Staff, there is Daily Documentation of Treatment Plan Required Services Implemented by the Residential Milieu Staff for that Day.

31.1 There must be at least one residential progress note, detailing a treatment plan required service provided by milieu staff, entered into the case record for each day the child is enrolled in the program.

This standard specifically requires that for every day that the child is actually in the program (under the supervision and direct care of program staff), milieu staff will implement at least one planned, proactive service required by the treatment plan. The treatment plan must require this service to occur at a specified frequency and duration in order to decrease or prevent the occurrence of the issue or problem being addressed in the goal and objective. Such services include but are not limited to milieu staff activities such as skill building and coaching.

If the child is away from the program on a home visit, etc., a note for each such day should be written indicating the absence from the program.

As needed, or PRN services by the milieu staff (what to do when a behavior occurs) and activities for monitoring progress are often appropriately included in the treatment plan, but these services would not meet the requirement for this standard.

31.2 Each residential progress note must be in compliance with PNMI Standard requirements 25 through 30 above.

For Standard 31, the "at least one residential progress note" each day requirement should be considered a minimum standard that should not limit the number of goals and objectives implemented in accordance with the treatment plan and documented by the residential staff for each child. Since youth spend a majority of their daily routine in the therapeutic residential milieu, it is likely that there will be multiple specific goals, objectives, and services that the residential staff will be proactively implementing and documenting on a daily basis.

Standard 32.

The DCF Monthly Treatment Plan Progress Report (MTPPR) is in the Record

32.1 There must be a DCF monthly treatment plan progress report in the case record (There should be a progress report for each calendar month or significant portion of the calendar month that the child is in placement. A child's enrollment in a program for fourteen or more calendar days warrants the submission of this report).

Standard 33.

The DCF Monthly Treatment Plan Progress Report must accurately represent services provided

33.1 Documentation of the frequency of services provided in The Monthly Treatment Plan Progress Report must be consistent with the actual services provided as documented in the progress notes.

Standard 34.

The Monthly Treatment Plan Progress Report (MTPPR) Addresses Progress made Towards the Goals and Objectives in the Child's Current Individual Treatment Plan

34.1 Each Monthly progress report must note the goals **and** objectives* from the individual treatment plan in effect during the reporting month. If the plan, goals and/or objectives change during the reporting month, the goals and/or objectives in effect for the majority of the reporting month shall be documented in the MTPPR.

34.2 Each Monthly progress report must state progress made toward current treatment plan goals **and** objectives.

*Note: The MTPPR in use at the time of implementation of these standards does not readily allow for the entry of objectives as well as goals. Until the new monthly treatment progress report is implemented, only the goals from the treatment plan are required.

Standard 35.

Record Contains Documentation that the Monthly Treatment Summary has been sent to Designated DCF Staff (For example: Area Office Mental Health Program Director/Parole Liaison)

35.1 There must be documentation in the case record that each DCF monthly treatment progress report was sent to the designated DCF staff (For example: a copy of a fax cover letter attached to the MTPPR or an initialed and dated notation on the MTPPR that the document was sent).

GENERAL DOCUMENTATION RULES:

1. When standards call for documentation to be entered on a face sheet, that face sheet is expected to be physically filed at the beginning of the case record. Although the term face sheet suggests that the document is comprised of a single page, multiple page documents are allowable, if necessary to present all required information.

For electronic case records, there should be a clearly identifiable window, tab, or selector that accesses the location of all face sheet information.

2. When standards call for a hand dated signature, the date written immediately after the signature is understood to be the date the signature was written on the document. Back dating signatures is not allowed.

Specific to progress notes, since such notes may not always be written at the time the service is delivered, it is understood that the date of the signature may be later than the date of service delivery identified in the progress note.

3. When standards require a licensed clinical practitioner's (LCP) review and signing of the treatment plan, the hand dated signature is understood to mean that the LCP has reviewed available assessments of, and progress information regarding the resident, and in doing so has determined that the treatment plan goals, objectives and services noted in the signed document are appropriate and necessary. The date of the signature is understood to be the date that the signature was written on the document as well as the date on which the plan was implemented or renewed, unless otherwise noted by the signing LCP (For example: "to be implemented upon admission").

4. All documents containing progress notes (clinical, residential, etc) must include the client's name and be signed and hand dated (or electronically signed and date stamped in an approved e-signature system) by the individual who provided the service. For situations in which multiple session notes are printed on the same document from a running computer record or file, each page of the printout must be signed and hand dated by the clinician who provided the service. Such signature is understood to indicate that the person signing the page provided each service noted on the dates and times indicated. If multiple persons provided the various services listed on a single page, each session note must be signed and hand dated by the person who performed the service noted.

5**.** Entering documentation into the case record

Progress notes must be entered into the case record within thirty days of the delivery of the service.
Treatment Plans must be entered into the case record within thirty days of the date of LCP sign-off, but must be available to program staff and auditors on the date of sign off.
All other documentation must be entered into the case record within thirty days of completion or receipt of the document.

6. For PNMI Purposes, a **Licensed Clinical Practitioner (LCP)** is any of the following:

(A) a **doctor of medicine or osteopathy** licensed under chapter 370 of the Connecticut General Statutes;

(B) **a psychologist** who is licensed under chapter 383 of the Connecticut General Statutes;

(C) a **marriage and family therapist** who is licensed under chapter 383a of the Connecticut General

Statutes;

(D) a **clinical social worker** who is licensed under chapter 383b of the Connecticut General Statutes;

(E) an **alcohol and drug counselor** who is licensed under chapter 376b of the Connecticut General Statutes;

(F) an **advanced practice registered nurse** who is licensed under chapter 378 of Connecticut General Statues;

(G) a **registered nurse** who is licensed under chapter 378 of Connecticut General Statutes and who has a minimum of one year of experience in the mental health field; or

(H) a **licensed professional counselor** who is licensed under chapter 383c of the Connecticut General Statutes.

No other licensed practitioners are recognized for the purposes of reviewing and authorizing treatment plans, and supervising treatment.

If you have any questions regarding these standards please contact the Supervisor or Program Supervisor of DCF's PNMI unit.