

**State of Rhode Island**

**Department of Human Services**

**Center for Child and Family Health**

**Certification Standards**

**Therapeutic  
Child and Youth Care**

**April 15, 2003**

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**State of Rhode Island**  
**Department of Human Services**  
**Center for Child and Family Health**  
**Certification Standards**  
**Providers of Therapeutic Child and Youth Care**

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**1.0 SERVICE INFORMATION AND BACKGROUND**

**1.1 Introduction**

There are several indicators of Rhode Island's current commitment to improve quality, accessibility and affordability in child care and youth care. For example, the child care system in Rhode Island has received national recognition for its effort in promoting quality programs. Working Mother magazine acknowledged this in 1999 by selecting Rhode Island as one of the top ten states in terms of its child care policies, e.g. income eligible child care subsidy offered to all qualifying families and state funded health insurance for eligible child care providers. In 1999, Parents magazine cited Rhode Island as one of five states with child care policies that strove to improve the lives of families. Other examples include the expansion of comprehensive child care and Head Start services, extension of the child care subsidy program to youth up to age 16 and increased professional development opportunities, including support for child care providers to be nationally accredited through the Starting RIte initiative.

However, the supply of licensed child and youth care providers for children with special health care needs is limited in Rhode Island. Children with special health care needs are those who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

The Rhode Island Department of Human Services (DHS) is soliciting applications from licensed center based child and youth care providers to become certified as providers of Therapeutic Child and Youth Care (TCYC) for Medicaid eligible children with special health care needs. These services are intended to support the participation of these children in typical child and youth care settings where such participation is determined to have potential positive benefits for the child. TCYC does not include the basic child or youth care itself that is billed separately to the family or other payer. The establishment of this certification process and the issuance of these Certification Standards provide the basis for determination of provider-agencies eligible to receive payment for provision of TCYC.

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To be a participating provider-agency of TCYC, interested parties must be licensed by the Department of Children, Youth and Families (DCYF) as a child day care center and/or school age care provider and certified by DHS as TCYC providers. It is anticipated that licensed Family Child Care Providers will be eligible to apply for Certification as a TCYC provider at a later date. If Head Start, Early Head Start or a Local Education Agency (LEA) provide child care that is before or after hours of their traditional program operation, they must be licensed by DCYF.

These Certification Standards further establish the procedures and requirements for TCYC services as administered by DHS.

Therapeutic Child and Youth Care requires prior authorization. These standards describe the basis and mechanism of prior authorization, as well as payment for services.

Recommendations to DHS for prior authorization for these services and for their subsequent renewals will be managed by CEDARR Family Centers. In all cases families are free to select the certified TCYC agency of their choice.

These Certification Standards serve to provide families, potential applicants, service providers and other interested parties with a full description of Therapeutic Child and Youth Care, including guidance as to certification requirements and methods for application. Sections 1 through 5 contain service description and background as follows:

- Section 1: Service Information and Background
- Section 2: Certification Process
- Section 3: Background and Rationale for Development of Therapeutic Child and Youth Care
- Section 4: Target Population and Location of Service Within the Continuum of Care
- Section 5: Service Description - Required Scope of Services

Section 1 provides an introduction to the service, Section 2 describes the process for certification and Section 3 contains a statement of the need for the service and the processes leading to development of these standards. Section 4 identifies the group of children that this service is expected to benefit and delineates how this service relates to the overall continuum of care. Section 5, Service Description, contains a detailed description of the service and identifies core requirements for the service.

The Certification Standards include two additional sections as follows:

- Section 6: Requirements for Organization of Service Delivery - Performance Standards
- Section 7: Qualified Entity Requirements

Sections 6 and Section 7 specifically describe the requirements for certification. Satisfactory compliance with these requirements must be demonstrated for certification; continuing compliance is required in order to maintain full certification status.

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Certification applications will be primarily focused on Section 6. Although certified entities must comply with the requirements set forth in Section 7, the requirement to demonstrate such compliance in the application itself is more limited. Attachment A, Application Guide, provides more detailed instruction as to how to develop the certification application.

### **1.1.1 Therapeutic Child and Youth Care**

TCYC is provided for Medicaid eligible children living at home and who have been diagnosed with certain significant physical, developmental, behavioral or emotional conditions, as well as those children living with a foster family. These children have chronic health care needs that require health and related services beyond those required by children generally. Section 4.0 provides greater discussion about the target populations for this service and criteria to be used in determining the appropriateness of the service for a child.

TCYC can only be provided when there is documented medical necessity for this service (See Appendix 1: Definition of Medical Necessity), and evidence that TCYC can meet the needs of the child with special health care needs.

Therapeutic Child and Youth Care is a specialized service delivered in DCYF licensed child or youth care centers. It is a program of care designed to maximize the inclusion and participation of Medicaid eligible children and youth with special health care needs who have been dismissed from or previously unable to participate in child and youth care settings.

In order for inclusion in child and youth care to truly be accomplished, children and youth with special health care needs must interact with their peers, who are typically developing, in a socially meaningful manner. This means that physical and social isolation in child and youth care must be avoided. Children or youth in TCYC must have the opportunity and supports necessary for them to engage and interact with children who are typically developing while they mutually participate in the activities in the child and youth care setting. This may, at times, require that children who are typically developing also be given help in interacting with their peers who have special health care needs.

These services are not intended to replace services for which these children are otherwise entitled through Early Intervention, Special Education, Head Start or any other program for which they qualify. These services are provided in accordance with an approved individualized Therapeutic Integration Plan with measurable goals and objectives. The Therapeutic Integration Plan must be an approved component of a CEDARR Family Center Family Care Plan and be developed by a licensed health care professional or certified special educator<sup>1</sup> in consultation with the licensed child or youth care program and family. There are three specific services for which certified TCYC providers can be reimbursed.

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<sup>1</sup>Currently licensed by Department of Health (DOH) in psychology, social work (LICSW), a registered nurse with a Masters degree, marriage and family therapist, mental health counselor and/or current Special Education Certification from the Department of Education (DOE) with a Master's Degree. Competency is established by formal education, continuing education credits, internships, work history and supervised practice.



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These are: 1) Therapeutic Integration Assessment and Plan Development, 2) Therapeutic Integration Direct Services and 3) Nursing services by a registered nurse. These are described below. The Child Care or Youth Care, itself, is paid for by the family or other entities. Medicaid does not reimburse for child or youth care tuition. Once approved by a CEDARR Family Center and authorized by DHS, the Therapeutic Integration Plan is implemented by the TCYC provider-agency.

#### **1.1.1.1 Therapeutic Integration Assessment and Plan Development**

This service includes two components: the assessment and the plan development. The first service component is the assessment to confirm the appropriateness of the child or youth care setting for the child and the child's ability to benefit from participation in child or youth care. The assessment will be done by a licensed health care professional or certified special educator and will include a review of the information gathered during the Initial Family Assessment (IFA) conducted by the CEDARR Family Center. This assessment also will include determination that the child is not able to participate in the care center without support and a systematic analysis of the way the child's special needs precludes participation. If it is determined that this participation is an appropriate part of the child's overall treatment plan and that participation can be achieved through TCYC services, then a Therapeutic Integration Plan will be developed which specifies the direct services of a therapeutic integration specialist to support participation. It is understood that at particular moments, these children may have physical, behavioral, cognitive, and/or communicative limitations that do not allow them to fully participate in specific activities. However every attempt must be made to overcome these barriers. The goal is to prevent isolation of these children and youth and promote interaction with typically developing children. The plan, therefore, must outline how these barriers are to be overcome and how successful inclusion is to be measured. The child must meet the clinical appropriateness criteria for service (refer to Section 4.2.1). In unusual circumstances, when it is determined that the child's needs are too complex and the level of support needed more intense than can be provided by the TCYC provider, the assessment will be forwarded to the CFC documenting the criteria for this determination. The CFC will then recommend to DHS whether the assessment will be reimbursed without development of a plan.

For most children referred for an assessment, it is anticipated that a plan will be developed which addresses therapeutic interventions and supports needed to overcome the specific barriers identified in the assessment. Refer to section 5.4.1. for more detail.

Therapeutic Integration Plans are renewable at 6-month intervals<sup>2</sup> using the same criteria for appropriateness as in the initial plan. However the initial assessment and plan development is a one time only reimbursable activity. Development of subsequent plans will be based on the ongoing work with the child and family and are not reimbursable.

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<sup>2</sup> This does not supercede Family Independence Program (FIP) authorizations which may be from 3 months to 1 year depending on the activity of the parent.

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### **1.1.1.2 Therapeutic Integration Direct Services**

The second reimbursable service is the actual Therapeutic Integration Direct Services provided to a child by a Therapeutic Integration Specialist (paraprofessional). Direct services are provided in accordance with the approved Therapeutic Integration Plan and under the clinical supervision of the Clinical Supervisor. The Director or Head Teacher will provide administrative supervision.

These direct services will address the functional skills and supports needed for successful participation and inclusion in the child or youth care setting. In some cases, this may be an extension of skills included in a child's Individual Educational Plan (IEP) or Individualized Family Service Plan (IFSP) to enhance transfer of learning and generalization to these more natural settings. This will be accomplished through coordination with the CEDARR Family Center and the local school system or Early Intervention Program. The overall goal of these services is to provide the support of a therapeutic integration specialist to facilitate the participation of the child in terms of interactions with other children, staff and materials to enhance cognitive, emotional and behavioral development.

### **1.1.1.3 Nursing Services**

In exceptional circumstances for children with intensive medical needs, a nurse may be present at specified times for assessment, a medical procedure or monitoring of health status. These are children with a physician's order stating the requirement that a skilled nurse be in attendance at the child or youth care setting for no more than one hour a day per child during their stay in child or youth care. This is separate from Private Duty nursing services (see Section 5.4.1.1).

DHS will authorize the provision of nursing services when included in the Integration Assessment and Plan that is reviewed by the CEDARR Family Center and contains an explanation as to the need for such service.

## **1.2 Intended Outcomes of Certification Standards and Services**

The development of Certification Standards and the provision of certified Therapeutic Child and Youth Care are intended to:

- 1) Enable children with special health care needs to receive the critical developmental therapeutic benefits through active participation and successful inclusion in child and youth care settings to the best of their abilities and to be valued members of those communities.
- 2) Improve the access to provision of services as authorized by CEDARR Family Centers. Certified TCYC direct service providers are expected to render efficient, cost-effective interventions aimed at integrating and maintaining children with special health care needs in natural environments, i.e. child or youth care.

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- 3) Provide the context for monitoring, oversight and assuring quality of TCYC provider-agencies by DHS (e.g. regular performance reports will be provided to DHS to assure that services are being rendered as authorized) and assessing the impact of TCYC on children's ability to participate in typical child and youth care settings.
  - 4) Increase provider capacity for rendering services to children and youth with special health care needs.
  - 5) Assure adherence to family centered principles in the service relationship between provider-agency and family.

### **1.3 TCYC as a CEDARR Direct Service**

Certification of provider-agencies for the provision of Therapeutic Child and Youth Care is intended to further the "Statewide Vision for Children and Families with Special Health Care Needs." This vision was developed by the Leadership Roundtable on Children with Special Health Care Needs, a representative group of family members, providers, public and private administrators and advocates convened for planning purposes by the Director, Department of Human Services.

Statewide Vision "All Rhode Island children and their families have an evolving, family centered, strength based system of care, dedicated to excellence, so they can reach their full potential and thrive in their own communities." Leadership Roundtable on Children and Their Families with Special Health Care Needs, April 15, 1999

CEDARR stands for Comprehensive Evaluation, Diagnosis, Assessment, Referral and Revaluation services and supports. The CEDARR Program Initiative includes two broad delivery system components:

- CEDARR Family Centers, and
- CEDARR Certified Direct Services

The CEDARR Family Center Certification Standards more fully describe the role of the CEDARR Family Centers and the related Certification Standards. They are available on line on the DHS website reached at [www.dhs.state.ri.us/dhs/dcedarr.htm](http://www.dhs.state.ri.us/dhs/dcedarr.htm)

CEDARR Direct Services are specific services developed pursuant to the CEDARR Initiative and available to Medicaid beneficiaries when included as part of an approved CEDARR Family Center Family Care Plan. Development of CEDARR Direct Services is based on two principles:

- 1) Identification of current service needs and gaps in health care services for children and families with special health care needs; and

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- 2) Establishment and operation of an accountable system for the purchase of appropriate, high quality services to meet those needs.

These CEDARR Direct Service Certification Standards for TCYC specify the requirements that must be met to be a certified provider and provide guidance to interested parties who may choose to apply for certification. DHS reserves the right to amend these standards periodically, with reasonable notice to participants.

### **1.3.1 Prior Authorization, Coordination with CEDARR Family Center, and Reimbursement**

TCYC requires prior authorization in order for a provider to be reimbursed for services. CEDARR Family Centers make recommendations to DHS for authorization of services. All claims are adjudicated by Electronic Data Systems (EDS) in accord with DHS and Federal Medicaid policy and program rules. TCYC provider-agencies are notified in writing by EDS that an authorization has been formally entered into the claims system. Services provided in the absence of a prior authorization shall not be reimbursed. Claims for all services (Assessment and Plan Development, Therapeutic Integration Services and nursing services) will be submitted by the certified provider agency and processed by EDS.

### **1.3.2 Period of Authorized Service and Reimbursement**

The period of authorized service is stipulated in the prior authorization (PA) notice. The PA stipulates the number of approved units of component services. Reimbursement will be based on services provided as part of a Therapeutic Integration Plan, i.e. therapeutic integration specialist hours and nursing services.

The maximum period for authorization of a TCYC Therapeutic Integration Plan is six months. There is no limit to the number of TCYC cycles that can be authorized by a CEDARR Family Center. A child can receive TCYC from only one TCYC agency during a given authorization period.

### **1.3.3 Coordination with CEDARR Family Center for Review and Prior Authorization from DHS**

A family may contact a CEDARR Family Center for a variety of reasons. Based on the child and family's interest, the CEDARR Family Center will conduct an Initial Family Assessment (IFA), working with the family to understand their special needs and circumstances, and review available options. As appropriate, the CEDARR Family Center develops a Family Care Plan (FCP) that may identify a range of specialized service options and providers, including recommendations for CEDARR Direct Services (e.g., TCYC).

If TCYC is identified as a potential direct service, the CEDARR Family Center will inform the family of available choices of certified provider-agencies for TCYC. The family, with guidance from the CEDARR Family Center, if desired, will choose the provider-agency from which they

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want to receive services. The CEDARR Family Center will provide information from its own assessment to the TCYC provider-agency to avoid duplication of effort and unnecessary repetitions by the family. This also minimizes the work otherwise required of the TCYC provider-agency to develop a proposed Therapeutic Integration Plan.

In developing the proposed Therapeutic Integration Plan, the TCYC provider-agency with the licensed health care professional or certified special educator and family will conduct a more focused assessment directed toward determining the specifics of the proposed Therapeutic Integration Plan in order to maximize the child's participation in the care center. The CEDARR Family Center will review the proposed Therapeutic Integration Plan. Based on its review and concurrence, a recommendation for authorization is made to DHS.

Appendix 2 provides a further outline of the CEDARR Family Center Review and DHS authorization process.

#### **1.4 Commitment to Family Centered Care**

The CEDARR Initiative seeks to incorporate the key elements of family centered, community-based care into practice. Participating providers of TCYC are required to develop practices and services consistent with the principles of family centered care. Core practices of family centered care include:

- 1) Incorporating into policy and practice the recognition that the family is the constant in a child's life, while the service system and support personnel within those systems fluctuate.
- 2) Providing individualized services in accordance with the unique needs and potential of each child and guided by the child and family specific care plan that recognizes health, emotional, social, and educational strengths, as well as needs.
- 3) Facilitating family/professional collaboration at all levels of hospital, home and community care.
- 4) Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.
- 5) Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational and geographic diversity.
- 6) Encouraging and facilitating family-to-family support and networking.
- 7) Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.

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- 8) Ensuring services that enable smooth transitions among service systems and natural supports, which are appropriate to developmental stages of the child and family.
  - 9) Full disclosure to families of any anticipated delays in start of services, changes in personnel, and provider-agency policies and procedures in the provision of Therapeutic Child and Youth Care.

## **2.0 CERTIFICATION PROCESS**

### **2.1 Submission of Certification Application Required**

There is no limit to the number of entities that may become certified as provider-agencies of TCYC. Applications for certification may be submitted by any DCYF licensed child or youth care facility seeking to become a provider of TCYC. All TCYC applicants will be evaluated on the basis of written materials submitted to DHS addressing Certification Standards. DHS reserves the right to conduct on-site reviews and to seek additional clarifications prior to final scoring.

Potential applicants may submit applications for certification to DHS any time after the issuance of these Certification Standards. Application reviews will be scheduled periodically by DHS based on receipt of applications. Provider-agencies will be notified of their certification status when the review is complete. Applicants should anticipate a minimum of six to eight weeks for the review process.

During the initial period of application review and certification subsequent to the issuance of these standards DHS sets forth the following schedule. TCYC provider-agency certification applications must be received by DHS by June 16, 2003 in order for the provider-agency to be certified by August 1, 2003.

### **2.2 Instructions and Notifications to Applicants**

This document sets forth the Certification Standards for direct service providers of TCYC. In accepting certification from DHS, Certified CEDARR direct service providers agree to comply with these certification standards as presently issued and as amended from time to time by DHS, with reasonable notice to providers.

These Certification Standards also provide the application guide for applicants. Sections 6 and 7 of this document identify the core standards against which applicants will be evaluated.

Within Sections 6 and 7, specific standards and expectations are identified. Applications will be scored on the basis of responses to each of these specific standards and expectations. Applications are to address each of these areas in the sequence presented. Applicants are to use the numbering system in these standards to identify the sections being addressed in the application.

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An Application Guide is presented in Attachment A to guide the organization of application materials. Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to the State for consideration in response to these Certification Standards will be considered to be Public Records as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception.

Interested parties are encouraged to contact the Center for Child and Family Health (CCFH) for further information and clarification. Letters of Interest are strongly encouraged to ensure that DHS is able to keep interested parties up to date regarding scheduled meetings or program clarifications that may be needed. Inquiries and completed applications should be directed to:

Sharon M. Kernan, RN, MPH  
Assistant Administrator  
Center for Child and Family Health  
Department of Human Services  
600 New London Avenue  
Cranston, Rhode Island 02920  
Phone: (401) 462-3392

Once a provider is certified as eligible to provide TCYC, the provider shall be enrolled with EDS as a provider of these services. If you have any questions about the enrollment form or enrollment process, please call EDS at 1-800-964-6211.

### **2.3 Information for Interested Parties**

Upon initial release of these CEDARR TCYC Direct Service Provider Certification Standards, DHS staff will be available to provide information for those pursuing certification applications. If appropriate, DHS will provide written addenda to these standards to further clarify certification requirements.

### **2.4 Certification**

As set forth in these standards, certification as a TCYC provider is required in order for DHS to reimburse a provider agency for provision of TCYC services. Certification requires that provider-agencies adhere to these standards and performance expectations, as well as provide periodic reports to DHS. These Certification Standards include certain performance standards.

Subsequent to certification DHS will monitor the performance of certified TCYC provider agencies and their continued compliance with certification requirements. Certified agencies are required to notify DHS of any material changes in their organization's circumstances or in program operations. On the basis of ongoing monitoring, including review of required reports submitted by certified provider-agencies, DHS may identify deficiencies in performance and/or

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compliance with certification requirements. Based on such review and related communications, certification status may be modified to Provisional Certification. Fully Certified and Provisionally Certified agencies will be reimbursed using different rate schedules (see Table 2 in Section 2.4.2 for Rate Schedules; see Section 2.5, “Continued Compliance with Certification Standards” for a fuller discussion of Provisional Certification).

#### **2.4.1 Possible Outcomes of Certification Review Process**

Certification applications will be reviewed and scored based on the degree to which an applicant demonstrates a program that complies with the requirements set forth in these TCYC Certification Standards.

Three basic outcomes are possible as a result of the application review process. These are:

- Certification with no conditions
- Certification with conditions
- Not certified

As a result of the review, provider-agencies may be deemed in compliance with all requirements and be offered “Certification with no conditions”. Alternatively, an applicant may describe a program that meets most of the Certification Standards, but for one reason or another does not fully comply with the certification requirements at the time of application submission. In such case the applicant may be offered “Certification with conditions” and application deficiencies will be identified by the State. The applicant will be required to address them by submitting an action plan with specific dates for addressing deficient areas of compliance. This plan must be accepted and approved by DHS.

In other cases the review team may determine that an application does not meet the requirements for certification and certification will not be offered to that agency. Deficiencies in the application will be identified. This will be done without prejudice and interested applicants will be encouraged to address deficiencies and submit an amended application. Certification is not a competitive process limited to a fixed number of providers. Rather, all applicants who demonstrate preparedness to comply with the standards will be certified.

#### **2.4.2 Certification Status and Reimbursement Schedules**

Reimbursement for services varies based on certification status. Table 1 lists the possible outcomes of the certification review process and related reimbursement rate schedule.



<b>Table 1: Certification Status and Applicable Reimbursement Schedule</b>	
<b>Certification Status</b>	<b>Reimbursement Rate Schedule effective</b>
<b>Certified</b> -with no conditions	<b>Schedule A</b>
<b>Certification</b> -with conditions	<b>Schedule A</b>
<b>Provisional Certification</b> ( <i>applies only where a previously certified agency is deemed to be out of compliance with standards; provisional certification status cannot last longer than six months; see Section 2.5</i> )	<b>Schedule B</b>

Table 2 lists each of the TCYC services and the related schedules of reimbursement for each unit of service for each child served.

<b>Table 2: Service Description and Schedules of Reimbursement For Each Child Served And For Each Unit of Service</b>		
<b>Service Description</b>	<b>Rate Schedule A</b>	<b>Rate Schedule B</b>
<b>Therapeutic Integration Assessment and Plan Development</b>	<b>\$ 280.00</b>	<b>\$ 238.00</b>
<b>Therapeutic Integration Services per child unit=30 minutes*</b>	<b>\$ 6.00</b>	<b>\$ 5.10</b>
<b>nursing services unit=15 minutes</b>	<b>\$ 16.50</b>	<b>\$ 14.03</b>

## **2.5 Continued Compliance with Certification Standards**

Certified TCYC providers shall comply with these TCYC Certification Standards throughout the period of certification. Failure of DHS to insist on strict compliance with all certification standards and performance standards shall not constitute a waiver of any of the provisions of these certification standards and shall not limit DHS' right to insist on such compliance. DHS will monitor and evaluate provider-agencies of TCYC for compliance with Medicaid and State laws, as well as these Standards and DHS regulations and policies pursuant to the management of TCYC. TCYC providers are required to provide periodic reports to DHS as identified in Section 6.7, "Service Monitoring and Reporting". For purposes of review, certified and provisionally certified providers will provide access to appropriate personnel and written records by DHS and/or its agents at reasonable times.

\* For this service, based on the staff to child ratios shown in Section 5.4.2, an individual Therapeutic Integration Specialist may provide and bill for more than one child at a time, up to the maximum allowable ratio.

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DHS reserves the right to apply a range of sanctions to providers that are out of compliance. These may include:

- a) Suspension of new referrals.
- b) Change of certification status to Provisional Certification.
- c) Recoupment of funds when violations of Medicaid regulations, State law, or DHS policies, including these Certification Standards have taken place.
- d) Suspension of certification, depending on severity of violation
- e) Referral to appropriate legal authorities.

### **2.5.1 Provisional Certification**

As a result of its review activities DHS may identify deficiencies wherein an agency is not in satisfactory compliance with the certification and/or performance standards. In such instance, DHS will notify the agency in writing of such deficiencies and will set forth a period of time within which the agency must come into compliance or provide a corrective action plan acceptable to DHS. Such corrective action plan will include specific steps to be taken to come into compliance and defined dates for achievement of those steps.

The length of the period set to come into compliance or to have a corrective action plan accepted by DHS will depend on the specific circumstances. In exceptional circumstances such a period may be as short as twenty-four (24) hours; under no circumstances shall the period exceed thirty (30) days from the date of notification of deficiency.

In the absence of a plan acceptable to DHS or in the event of failure to meet the timelines set forth in the corrective action plan, DHS retains the right to modify certification status of the agency to provisional. Provisional Certification will remain in effect until DHS determines that there is, in its judgment, satisfactory resolution of deficiencies. The duration of Provisional Certification status shall not exceed six months at which point continued non-compliance with DHS requirements shall result in de-certification. The foregoing represents DHS' preference to engage in constructive remedial activity where deficiencies may be present. The foregoing shall not however, limit DHS' rights to de-certify a provider in the event of non-compliance and failure to take responsive action to address deficiencies. Nor does it limit any remedies available to DHS under existing federal and state Medicaid law and policy.

### **2.6 Licensure Requirements for Service Providers in Certified TCYC Provider Agencies**

All TCYC agencies must maintain their full license issued by DCYF. In addition, a requirement for certification is that all clinical staff engaging in Therapeutic Assessment, Plan Development and clinical supervision of direct service workers must be health care professionals licensed by the Department of Health (DOH) of Rhode Island as a psychologist, licensed independent clinical social worker, or registered nurse with a master's degree or be a special educator certified by the Department of Education (DOE). In addition, licensed clinical staff must be able to demonstrate competency to render supervision to therapeutic integration staff. Note that a list of clinical staff,

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their disciplines and license/certification number must be included in the application for certification. (See Appendix 3). This includes nurses providing nursing services.

## **2.7 DHS Responsibilities**

DHS has the responsibility to inform appropriate State agencies of any instances of fraud, suspected fraud, misuse of Medicaid funds and/or professional misconduct.

As a Medicaid provider, the provider-agency is obligated to comply with all applicable state and federal rules and regulations. Certified provider-agencies agree to comply with DHS program requirements. DHS reserves the right to amend program requirements from time to time, with reasonable notice to participating provider-agencies.

### **2.7.1 Oversight and Authorization**

DHS, in accordance with Medicaid regulations, may place limits on services (e.g., establish amount, duration, and scope of services) and exclude any item or service that it determines is not medically necessary, is unsafe, experimental, or is not generally recognized as an accepted method of practice.

## **3.0 BACKGROUND TO DEVELOPMENT OF THERAPEUTIC CHILD AND YOUTH CARE**

Therapeutic Child and Youth Care is being developed because there is a demonstrated need for therapeutic interventions in child and youth care settings to support the participation of children or youth with special health care needs. Child and youth care provides important opportunities for the development of socialization, communication and adaptive behavior skills for children. These can be particularly critical for children with special health care needs who may be deficient in such areas due to both disabling conditions and lack of opportunity for participation in natural community settings. Lack of opportunity for such participation can further limit a child's ability to progress and offset the positive benefits of other therapeutic regimens in which the child is engaged. This participation requires that children and youth with special health care needs not just be present or be physically "located" in a child or youth care setting. They must, with the help of supports and to the best of their ability, be "included" in activities in a socially meaningful manner with their typically developing peers.

The Rhode Island Child and Youth Care community brings a strong history and commitment to providing positive and secure environments for children. For some children, participation in community life, e.g. child and youth care, is not an option because facilities are not able to provide the necessary supports for safe and full engagement. The specific needs of children with special health care needs are widely varied and may include the need for positioning, behavioral cueing, and reinforcement of appropriate behaviors. Because these children are sometimes not able to participate, they are often isolated from their peers and inhibited in their social, communicative and behavioral development. The existing services used by these children may, in fact, promote isolation since they do not provide opportunities for full participation with typically

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developing peers. Examples of services that these children may be receiving currently or may also be eligible for are Private Duty Nursing, Certified Nursing Assistance and Home Based Therapeutic Services. The following sections provide a brief description of those services and the current populations being served.

### **3.1 Private Duty Nursing Services (PDN)**

Through Medicaid and the EPSDT benefit there are approximately 135 children receiving private duty skilled nursing care services in their homes in Rhode Island on a one-on-one basis. The program serves children from birth to age 21 who are SSI or Katie Beckett eligible and who have complex medical needs or chronic illnesses. Services include assessment, planning, nursing interventions and teaching family and caregivers necessary skills to safely maintain the child at home. Many of these children do participate in daily activities outside of the home (e.g. school), with sufficient supports. However, after those activities are completed for the day, they must rely on home-based services. With the additional supports of TCYC, many of these children may be able to receive the beneficial effects of engaging in activities with other children outside of the home in a child/youth care setting.

A wide variety of conditions exist, ranging from children requiring continuous assistance of respiratory support (i.e. ventilator dependent), to those requiring intermittent treatment and intermittent nursing care.

### **3.2 Certified Nursing Assistant (CNA) Services**

Through Medicaid and the EPSDT benefit there are approximately 100 children who receive CNA services in their home on a one-on-one basis. These children are Katie Beckett or SSI eligible. These services are authorized to assist the family in supporting the child's activities of daily living including personal care, feeding, dressing, mobility and rehabilitative or habilitative needs. These services are provided by a certified nursing assistant and supervised by a Registered Nurse.

### **3.3 Home Based Therapeutic Services (HBTS)**

Over 400 children are currently receiving Home Based Therapeutic Services through Medicaid and the EPSDT benefit. These children live at home and participate in the community and receive one-on-one services at home to address skill development or retention of skills to reduce or ameliorate deficits in cognitive, communicative, psychosocial and physical functioning. These are children who are eligible for Katie Beckett, SSI, Adoption Subsidy or RItE Care. Services are authorized for the purposes of maintaining, stabilizing or improving the child's current levels of functioning. Children receiving these services have a range of moderate to severe diagnoses, including autism spectrum disorders, behavioral health issues, and developmental disabilities. This service is for children with high intensity special health care needs.

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### **3.4 Private Duty Nursing and Therapeutic Child and Youth Care Workgroup**

In June 2001, at the direction of the CEDARR Policy Advisory Committee, the Private Duty Nursing and Therapeutic Child Care Workgroup was convened. The Workgroup, which included family members, representatives of provider agencies, and state agency staff met four times during June.

Core problems of the shortage of nurses and the resultant unfilled nursing shifts in Private Duty Nursing were identified, as well as several related concerns. Issues raised included families serving as their own care coordinators, consistent lack of shifts being filled, lack of continuity of care, and lack of nursing agency involvement in hospital discharge planning.

In reviewing these concerns the Workgroup agreed that potential solutions should focus broadly on the needs of families rather than exclusively on ways to address the problems of delivering private duty nursing services

Therapeutic Child and Youth Care services were presented as a further service option which may provide an alternative or complement to private duty nursing or to other more restrictive services.

However, it was noted that current child and youth care centers may not have the requisite supports to provide this service. A recent survey of several hundred of these centers indicated that only 5% of the children they serve have special health care needs and 43% of the centers had to ask a child to leave because of behavior problems over the past 6 months.

DHS has developed certification standards for Therapeutic Child and Youth Care that are intended to address the key issues identified by both the workgroup and child care providers. TCYC is intended to provide the necessary supports in order to increase access to and options for child and youth care for children and youth with significant special health care needs.

## **4.0 TARGET POPULATION AND LOCATION OF SERVICE WITHIN CONTINUUM OF CARE**

### **4.1 Eligibility**

The population eligible to be served by Therapeutic Child and Youth Care must be:

- 1) Medicaid eligible children, from birth to their nineteenth birthday, since this is the maximum age for which child and youth care centers licensed by DCYF are able to provide care to children with special health care needs. This includes children who are eligible for Medical Assistance through Supplemental Security Income (SSI), Katie Beckett, DCYF Adoption Subsidy, Rite Care, and Rite Share. These children have potentially chronic conditions (twelve months or longer in experienced or expected duration) and moderate to severe cognitive, developmental, medical and/or psychiatric conditions whose level of functioning is compromised, AND

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- 2) Children who would not otherwise be entitled to these services as a result of their eligibility for other programs e.g. Special Education, Early Intervention, Head Start, etc., AND
  - 3) Children who meet clinical appropriateness criteria and who have been dismissed or otherwise unable to participate in child or youth care because of their specialized medical, developmental or behavioral health care needs and for whom inclusion strategies can be developed and supported so that they could benefit from this service.

#### **4.2 Therapeutic Child and Youth Care Within the Continuum of Care; Appropriateness of this Level of Care**

TCYC is a service option within the continuum of care. It is not as restrictive as the one to one services provided in Home Based Therapeutic Services (HBTS), Certified Nursing Assistant Services (CNA), Private Duty Nursing Services (PDN), a Day Treatment Program, or residential level of care. TCYC provides opportunities to maximize participation with typically developing peers in natural environments. TCYC services may be provided in conjunction with other services, e.g. HBTS, as part of a coordinated program of care. However, complementary services such as HBTS and TCYC may not be provided at the same moment in time in a single setting.

As a point of reference, Appendix 4 includes a description of conditions that may be associated with the target population and TCYC. Decisions regarding the appropriateness of this intervention need to take into consideration the appropriateness criteria for TCYC set forth below.

##### **4.2.1 Clinical Appropriateness Criteria for Initiation of Service**

These criteria pertain to the initial determination of appropriateness of this service as recommended by a CEDARR Family Center and agreed to by the family. High priority is given to children who have previously been excluded from or denied access to Child or Youth Care due to lack of support for their special health care needs.

- 1) The child demonstrates symptomatology consistent with a DSM-IV or ICD-9 diagnosis, and on the basis of best available evidence can be expected to benefit from TCYC intervention.
- 2) The child presents with medical and/or physical condition(s) that require therapeutic supports in order to participate in child or youth care, but does not require consistent one-on-one support to participate.
- 3) The child requires support in order to safely participate, remain stable, and function appropriately within the child or youth care center.

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- 4) The child, the parents, or the child's legal guardian, when appropriate, are willing to accept and cooperate with TCYC, including the degree of parental participation outlined in the TCYC Plan.
  - 5) Child is currently receiving HBTS, PDN, CNA or another more intensive service and could benefit from TCYC.
  - 6) Failing the presence of TCYC, the child would require a more restrictive and isolating service (e.g. Private Duty Nursing, Certified Nursing Assistant, Home Based Therapeutic Service, Day Treatment, Residential or Inpatient Services).
  - 7) The child can be reasonably expected to succeed in the child or youth care setting with supports, as demonstrated by interacting with peers who are typically developing in the activities of the center.
  - 8) Successful participation can help to maintain or improve functioning in communication, socialization, and behavioral or cognitive development.

#### **4.2.2 Appropriateness Criteria for Continuing Care**

Reasons for a Therapeutic Integration Plan at this level of care to be continued and/or reauthorized involve the following criteria:

- 1) Severity of condition(s) and resulting impairment continue to require this level of intervention in order for successful participation in child or youth care.
- 2) The Therapeutic Integration Plan is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The intervention is appropriate and successful in promoting maximum participation.
- 3) Progress or maintenance of level of functioning continues. Progress in relation to goals is clearly evident, measurable and described in observable terms.
- 4) Therapeutic Integration Plan objectives have not yet been achieved. Documentation supports the need for continued interventions aimed at full participation, independent of therapeutic supports.
- 5) The family or caregiver is participating to the extent agreed upon in the Therapeutic Integration Plan.

#### **4.2.3 Discharge Criteria**

Reasons to end TCYC services can include any of the following criteria:

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- 1) Individual's documented Therapeutic Integration Plan goals and objectives have been successfully met and the child is able to participate in care without therapeutic supports.
  - 2) Withdrawal of consent for intervention from the individual's parents or legal guardian.
  - 4) Loss of Medicaid eligibility (See Appendix 5: Provider Responsibility for Monitoring of Medicaid Eligibility).
  - 5) Setting is no longer appropriate due to transition to another phase of life (e.g. from child care to school, is 19 years of age, etc.).
  - 6) Child is not able to benefit from participation in child or youth care with peers who are typically developing.

#### **4.2.4 Discontinuing Services**

Reasons for a Therapeutic Integration Plan to be terminated can involve any of the following criteria:

- 1) Loss of Medicaid eligibility (See Appendix 5: Provider-Agency Responsibility for Monitoring of Medicaid Eligibility).
- 2) Issues that may necessitate termination or temporary suspension of care during a period of authorized intervention include:
  - a) The individual is at risk of harm to self or others, or sufficient impairment exists requiring a more intensive level of service beyond TCYC and this risk continues in spite of repeated modifications in the Therapeutic Integration Plan.
  - b) The individual, family, or guardian is not successfully following the provider-agency's program rules and regulations, despite multiple, documented attempts to address these issues.

All instances and circumstances that effect temporary suspension of services or termination are serious and should be avoided if at all possible since it can have a significantly negative impact on the child and family. Provider-agencies have the obligation to contact the CEDARR Family Center and to collaborate with them to effect a smooth transition, and are required to conform to the rules and requirements stipulated by DHS .

### **4.3 Potential of Service and Limitations of Service**

#### **4.3.1 Potential of Service**

TCYC is unique because services are delivered in child and youth care settings with ongoing communication with parents, CEDARR Family Center, school or Early Intervention program to



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maximize transfer of learning and generalization from the care setting to other settings and vice versa. Child or youth care settings provide opportunities for growth and development that do not exist in more restrictive settings. Successful participation of the child with supports enables the child to gain skills that enhance participation that would not be possible without those supports. As children learn to apply their skills within age-appropriate community settings, TCYC enhances their abilities to actively participate as valued family and community members. Since therapeutic child and youth care provides opportunities for children to learn and model from their typically developing peers, this learning can be expected to broaden their engagement in other settings. This allows for consistency across settings and improvement in communication, behavior, psychosocial skills, and overall developmental functioning, which permits successful participation of a child receiving TCYC.

Through a strong relationship between the CEDARR Direct Service Provider-agency and the CEDARR Family Center, a mutually reinforcing integration of services for the child and family can be achieved.

#### **4.3.2 Limitations of Service**

DHS or the CEDARR Family Center reserves the right to determine that TCYC is being used appropriately to reach the target populations. The degree of appropriateness will depend on the target population served and the individual needs of the child. The following guidelines shall be followed:

- 1) A course of CEDARR Direct Service may be recommended as part of a Family Care Plan developed by a CEDARR Family Center. TCYC providers are expected, when appropriate, to complement and coordinate with other services already in place or being recommended for the individual AND
- 2) For children with special health care needs, an evaluation by an appropriately licensed health care professional must have taken place prior to the start of an initial TCYC Therapeutic Integration Plan to assure that the child can safely participate in care. This information will usually be secured as part of the CEDARR Family Center process. AND
- 3) TCYC will not exist in isolation when other supports are indicated (e.g., family or individual psychotherapy, medical treatment, school services and/or Early Intervention). AND
- 4) When children do not meet admission criteria for TCYC, other services should be investigated. AND
- 5) TCYC will not take the place of services provided more appropriately in the home and/or on a one on one basis, e.g. by Private Duty Nursing or Home Based Therapeutic Services. However, it is recognized that some children may require TCYC in conjunction with other services, such as Private Duty Nursing or HBTS.

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## **5.0 SERVICE DESCRIPTION - REQUIRED SCOPE OF SERVICES**

### **5.1 Service Name and Definition**

Therapeutic Child and Youth Care is a set of specialized supportive health services delivered in DCYF licensed child and youth care settings. TCYC represents an integrated set of service components involving the provision of TCYC provided in accord with an approved individualized Therapeutic Integration Plan with measurable goals and objectives aimed at maximizing the participation of children and youth in natural inclusive child care settings. All Therapeutic Integration Plans must be developed by a designated licensed health care professional or certified special educator in consultation with the TCYC agency and the family. Once approved by a CEDARR Family Center and authorized by DHS, the TCYC staff implements the Plan.

### **5.2 Service Components**

TCYC has the following service components:

- Therapeutic Integration Assessment and Plan Development
- Therapeutic Integration Direct Service
- Nursing services, when indicated

### **5.3 Units and Rate of TCYC Services**

Rates of reimbursement are based on the certification status of the provider-agency. The provider-agency may be fully certified or provisionally certified based on compliance with Certification Standards, including reporting requirements and levels of performance as stipulated in these standards. It is anticipated that provisional certification will be an unusual event. Refer to Table 2 in Section 2.4.2 for the authorized rates for each service.

Unless otherwise specified by DHS, provider-agencies will be reimbursed only for the units of service actually delivered to a child each month. The rate for the therapeutic assessment and development of the therapeutic integration plan is fixed.

For Therapeutic Integration Services a unit is one half hour of service (30 minutes). For nursing services a unit is 15 minutes. The child must be present to bill for this service.

TCYC provider-agencies are to comply with all established DHS billing reimbursement practices, and all future modifications as directed.

## 5.4 Description of Service Components

Table 3 provides a description of service components, required personnel qualifications, rates, range of approved hours, and functions assigned to each service component. Further elaboration is contained in sections 5.4.1 - 5.4.6.

**Table 3: TCYC Services**

TCYC Service Name	Personnel	Qualifications	Approved Units Per plan	Service Description
<b>Therapeutic Integration Assessment and Plan Development</b>	Licensed health care professional/certified special educator	<ul style="list-style-type: none"> <li>Licensed health care professional or certified special educator with established competency in working with children with special health care needs*</li> </ul>	Fixed Price	<ul style="list-style-type: none"> <li>Assessment of a child's needs for successful participation, development of Integration Plan and writing of goals, objectives and interventions to enable successful participation.</li> </ul>
<b>Therapeutic Integration Direct Services</b>	Therapeutic Integration Specialist	<ul style="list-style-type: none"> <li>19 years old, high school graduate or equivalent, plus 2 years of supervised experience working with children with special health care needs</li> <li>OR</li> <li>Child Development Associate Credential (CDA)</li> <li>OR</li> <li>Associates degree in human services</li> </ul>	<ul style="list-style-type: none"> <li>Minimum 2 units per day</li> <li>Maximum 20 units per child per day</li> <li>1 unit=30 minutes</li> </ul>	<ul style="list-style-type: none"> <li>Interventions in the child or youth care setting</li> <li>Implementation of child's individualized Therapeutic Integration Plan</li> <li>Full documentation of child's progress</li> <li>Provided under the supervision of the clinical supervisor</li> <li>Includes supervision of the Therapeutic Integration Specialist for clinical purposes of 30 minutes per child/per week by the clinical supervisor</li> <li>Active communication with families</li> </ul>
<b>Nursing Service</b>	Registered Nurse	Registered Nurse	<ul style="list-style-type: none"> <li>Minimum 0 units per day</li> <li>Maximum 4 units per child per day</li> <li>1 unit=15 minutes</li> </ul>	<ul style="list-style-type: none"> <li>Includes assessment, medical interventions or monitoring of the child's health status in the child or youth care setting</li> </ul>

\*Currently licensed by Department of Health (DOH) in psychology, social work (LICSW), registered nurse with a Masters degree, marriage and family therapist, mental health counselor and/or current Special Education Certification from the Department of Education (DOE) with a Master's Degree. Competency is established by formal education, continued education credits, internships, work history and supervised practice.

### 5.4.1 Therapeutic Integration Assessment and Plan Development

When a child has been referred by a CEDARR Family Center to a DHS certified TCYC provider, the licensed health care professional or certified special educator in collaboration with the family will carry out an assessment to determine how the child can successfully participate in child care with therapeutic supports. In order for the assessment to be effective in making these decisions, the licensed health care professional or certified special educator must be knowledgeable about events in the daily schedule of the child or youth care setting, the physical aspects of the child/youth care environment, the needs of other children/youth in the setting, staff and parent's issues in relation to inclusion of children with special health care needs, as well as the

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curriculum, schedule and daily activities of the program. The assessment will also include a review of information gathered by the CEDARR Family Center in their Initial Family Assessment (IFA) and analysis of the way the child's special needs otherwise preclude the child's ability to participate in child or youth care. In addition, each of the following areas must be considered from the perspective of the individual child's abilities, challenges and needs as they relate to the child's or youth's participation in care. (See Appendix 6, Sample Assessment Protocol):

- health/medical/nutrition
- personal care
- social interactions
- play
- activities and interests; communicating with and understanding others
- understanding concepts and problem solving
- motor skills
- behavior and safety

The factors to be considered in this process include the following:

- child's age
- type, nature and course of the presenting condition
- diagnosis
- impact on family functioning
- other treatment or educational services being received
- overall functioning of the child as it relates to ability to participate
- expectations for progress

If it is determined that the child needs therapeutic services to participate and benefit from an inclusive child/youth care experience, a plan will be developed that addresses therapeutic interventions based on the child's strengths to overcome the specific barriers to participation identified in the assessment. It is expected that the plan will be developed in collaboration with the family, child/youth care provider and the Clinical Supervisor. The family signs the plan in acknowledgment of their participation. TCYC services will not be approved without the family's participation with Plan Development and Implementation.

The Plan must relate to the specific findings in the assessment and should be structured around routines and activities. It will also include a description of the therapeutic services, with measurable goals and objectives detailing the approaches, interventions, materials, activities, accommodations and supports required to assist the child to actively be included and participate in activities with peers who are typically developing. The plan must show how these socially meaningful interactions are to be measured and what will be the indicators of success. (See Appendix 7, Development of Therapeutic Integration Plan).

On the basis of the TCYC plan, the child will be able to participate in child or youth care. The schedule for this will be included in the plan. It may be, for example, that the child participates

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part time, e.g. on certain days or parts of days. Some plans may call for increased participation over time. Other plans may call for decreased therapeutic support over time as the child transitions into Child or Youth Care without additional supports. The plan will specify the following:

- When the Therapeutic Integration Services will be available.
- The duration and frequency of supervision of a Therapeutic Specialist (paraprofessional) by the Clinical Supervisor
- Expectations for regular communication with the family (See Appendix 8).
- Circumstances when nursing services are required (it is expected this person will be in addition to the nurse or medical consultant required by DCYF licensure regulations. The role of the nurse will be clearly specified in the Therapeutic Integration Plan).

The goals and objectives included in a Therapeutic Integration Plan, when applicable, should be consistent with the goals of the IEP or IFSP to facilitate the transfer or generalization of learning from one setting to another. All goals, objectives and interventions or supports included must be based upon the written recommendations from the licensed health care professional or certified special educator. The TCYC supports are not substitutes for therapy or services provided by licensed therapists in public schools, Early Intervention programs or other settings.

#### **5.4.1.1 nursing services**

For certain children due to their medically necessary level of care, services by a registered nurse will be required in addition to the direct services of a therapeutic specialist. If a child requires one on one nursing services or therapeutic intervention services constantly, other more appropriate services, rather than TCYC should be recommended.

Nursing services include assessment, medical intervention and monitoring of health status in the child or youth care setting. Children with chronic medical conditions who are considered medically stable and require daily skilled care should be assessed for appropriateness for TCYC with an emphasis on the following:

- The stability of the child's condition
- The frequency of medical management, including medication administration, treatments, and skilled assessment
- The potential for exacerbation of medical problems
- The child's activity tolerance as it relates to the medical condition
- The child's tolerance to delays in treatment

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Children who experience substantial health problems, who have unstable medical conditions, and who have recurring acute exacerbations requiring ongoing therapeutic interventions may not be appropriate for TCYC.

Examples of children who may not be appropriate for TCYC:

- A child with a tracheostomy during the first 3 months post discharge
- A child with a severe seizure disorder requiring cardio/respiratory monitoring
- A child with significantly impaired airway clearance requiring suctioning
- A child requiring nasogastric tube feedings who is at risk for aspiration
- A child requiring medications and treatments with frequent dosage adjustment, regulation, and/or monitoring

Examples of circumstances under which nursing services may be needed include:

- A child who requires intermittent catheterization
- A child who requires monitoring of vital signs
- A child who requires enteral tube feedings
- A child who requires dressing changes
- A child who requires skilled assessment

Nursing services should not exceed one hour per child per day in child or youth care.

#### **5.4.2 Therapeutic Integration Direct Services**

Therapeutic Integration Services are provided to a child by a Therapeutic Integration Specialist (paraprofessional) under the supervision of the Clinical Supervisor<sup>1</sup> in accordance with the approved Therapeutic Integration Plan. In special circumstances, nursing services will be required. The overarching goal of these services is to provide the supports and services necessary to maximize the child's participation with children or youth who are typically developing.

Therapeutic integration services support successful participation. To accomplish this, the direct services will focus on the engagement of the child with other children, staff and in routine activities of the center. The goals of these services may include:

- increasing communication with and understanding of others
- increasing involvement in activities
- enhancing imitation

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<sup>1</sup> Administrative supervision is provided by the head teacher or Agency Director.

- generalizing social interactions
- developing independence skills
- decreasing aggression or other maladaptive behaviors
- learning problem solving skills (e.g., organization, conflict resolution).
- supporting activities of daily living

Services are provided in the context of routines of the child or youth care center for an approved number of hours per week.

The Therapeutic Integration Specialist is responsible for implementing the Therapeutic Integration Plan in the child or youth care setting. This individual(s) provides the accommodations and modifications necessary to maximize participation of the child as directed by the Therapeutic Integration Plan. Information is collected on each goal and objective aimed at optimizing the participation of the child and is used to gauge the progress toward active participation.

TCYC certification requires that a specific Therapeutic Integration Specialist to child ratio does not exceed that which is listed below. (The ratio may be less than that listed.) Staff for TCYC do not impact or count toward DCYF child/staff ratios. This is above and beyond those ratios. This ratio varies according to the age range of the children. For TCYC, the maximum child/Therapeutic Integration Specialist ratio is listed below. At no point can the child/Therapeutic Integration Specialist ratio exceed what is shown.

<u>Child's Age</u>	<u>Maximum Therapeutic Integration Specialist Staff/ Children with Special Health Care Needs Ratio</u>
6 wks-18 months	1 to 3
18 months and older	1 to 4

The Therapeutic Integration Specialist is to be employed by the child or youth care center for the purpose of working with the child care staff in working with children with special health care needs. The Therapeutic Integration Specialist receives administrative supervision from the Head Teacher or Director (See section 6.5.2.3 for required qualifications).

## **5.5 Intensity of Therapeutic Integration Services and Therapeutic Approaches**

Therapeutic Integration Services intensity refers to the number of hours of direct therapeutic integration services per week authorized in an approved Therapeutic Integration Plan. Therapeutic integration intensity requires ongoing monitoring to ensure its appropriateness during an authorized period of service.

Overall, there is no single approach indicated for the population of children eligible to receive Therapeutic Integration Services. Some children with special health care needs may need a gradual introduction to care and consequently, their plan would include a phasing in of hours of

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Therapeutic Integration Services. Successful integration and participation is more involved than just the number of hours of child care per week for a child. The most successful models involve providing the supports and accommodations consistently needed to facilitate participation of the child in the interactions and activities of the child and youth care center, at the child's pace.

## **5.6 Duration and Continuation of Services**

The maximum duration or length of time for services delivered through an authorized Therapeutic Integration Plan is six months. For a Medicaid eligible child under 19 years of age, there is no limit to the number of Therapeutic Integration Plans that may be approved for an individual child. Services are provided on a weekly basis for an approved number of hours for a period of up to six months. Therapeutic Integration Plans may be modified based on formal action by the CEDARR Family Center, following consultation with the provider-agency and the family.

## **5.7 Categories of Therapeutic Integration Plan Requests**

### **5.7.1 New Therapeutic Integration Services Plans**

A new Therapeutic Integration Plan is defined as either a Plan written for any child when there is no history of TCYC or the first Therapeutic Integration Plan written for a child by a particular provider-agency. Refer to section 5.11.

#### **5.7.1.1 Reauthorization of Therapeutic Integration Plans (Renewals)**

A reauthorization request is necessary when a Therapeutic Integration Plan is requested to continue for an additional period of time with the current provider-agency. This plan includes the results of progress on goals and objectives during the past or soon to end Therapeutic Integration Plan aimed at increasing participation in the care setting. See Section 5.10 for procedural directives.

## **5.8 Provider Agency, Family Involvement and Responsibility**

TCYC is a community-based service through which a child and family are provided certain intervention services. These standards identify a series of requirements for certified provider-agencies with regard to areas such as family-centered care, communication and coordination with the family.

Provider agencies shall maintain active communications with families and provide daily reports on the child's experiences during participation in TCYC. These communications may be brief summaries organized in accord with the activities of the agency or in accord with the Therapeutic Integration Plan. Parents have the right to refuse a Therapeutic Integration Specialist from working with their child at any time during the course of child or youth care.



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Provider-agencies should reasonably expect that families would recognize and respect the roles and responsibilities of providers. In order for TCYC to be effectively and safely provided, assurance must be given that other staff members and family will work positively with the provider-agency in maintaining a collaborative care relationship. The provider-agency must guide and assist their staff in the delivery of care, and has the responsibility for creating a climate which is responsive to the child's and family's needs, and supportive to its personnel.

In order for TCYC to be successful, all staff and families must be committed to the positive benefits of inclusion of children or youth with special health care needs in their care settings. It is expected that the directors of provider agencies will take deliberate action through the provision of training and other less formal methods to assure that children and youth with special health care needs are included as valuable members of the care setting.

Staff, families and peers who are typically developing should be oriented to the unique characteristics of each individual child or youth with special health care needs. This can be accomplished as a component of demonstrated appreciation for diversity, in general. Special health care needs, like other aspects of diversity, means that the child or youth may exhibit greater variability in learning, development, behavior and appearance.

## **5.9 Transportation**

Transportation to and from the child or youth care setting is not a reimbursable component of TCYC.

## **5.10 Therapeutic Integration Plan Authorization and Renewal**

- 1) It is expected that parents are involved in the development of all Therapeutic Integration Plans with the Clinical Supervisor and provider-agency well in advance of the date the Plan is to be submitted for reauthorization/renewal. Clinical Supervisor and provider-agencies shall allow parents sufficient time to review the Therapeutic Integration Plan (minimum of five (5) calendar days) prior to submitting it to a CEDARR Family Center. During this time, parents shall have the opportunity to meet with the Clinical Supervisor to discuss any questions or concerns they may have regarding their child's plan.
- 2) Renewal plans must be submitted a minimum of thirty days prior to expiration to allow time for review and communication and entry of the plan re-authorization into the claim payment system. The start date for DHS and re-authorization for services will not be less than thirty (30) days from the date of submission of the renewal plan. Services for children are not to be discontinued or interrupted due to the late submission of a renewal plan. There will be no retroactive approval of plans.
- 3) For Therapeutic Integration Service Plans requesting reauthorization of services the following information should be included:

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- a) Therapeutic Integration Direct Service history which includes a discussion of the content of the previous plan, an assessment of the child's response to the plan goals and interventions for successful participation and inclusion. Specifically, the re-authorization request should include the areas focused on in the goals and objectives of the previous therapeutic integration plan and modifications made to that plan. A statement should also be included regarding how the child continues to meet the clinical appropriateness criteria for this service. The content of the revised plan will include the same components as required in Section 5.4.1. Development of renewals are not separately reimbursable.
  - b) Dates of service for all previous Therapeutic Integration Plans
  - c) Number of direct service hours approved for the entire therapeutic integration period
- 4) For each plan, include a schedule of the days and times services will be delivered.
  - 5) If a child regresses and now requires a 1:1 staff ratio consistently, TCYC is no longer an appropriate service since the child no longer meets the appropriateness criteria (Section 4.2.2). The Clinical Supervisor and Director of the TCYC program should make this determination and a referral should be made to a more appropriate program via the CEDARR Family Center (CFC).
  - 6) Parents are required to participate in the development of and to approve all initial and renewal Therapeutic Integration Plans. The parent must sign the plan prior to its submission to the CFC to indicate participation in the development of the Therapeutic Integration Plan, and agreement with the contents of the plan.
  - 7) If a provider-agency wishes to change the number of hours within the approved period, a proposed addendum to the Therapeutic Integration Plan is required indicating the reasons for the requested change. The proposed addendum and a signed parent signature form must be submitted to the CFC for review. Requests will only be processed by the CFC after all documentation has been received.
  - 8) Both initial and renewal Therapeutic Integration Plans are to be submitted to a CFC a minimum of 30 days prior to the date services are anticipated to begin.
  - 9) Responses to reviewer's comments and additional information requested by the CFC reviewers must be responded to in writing within 9 calendar days upon receiving the request to avoid delaying authorization of services. Late responses may result in disruption of reimbursement for care re the period affected by the delay.

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## 5.11 Therapeutic Integration Service Performance Standards

Certified TCYC agencies are expected to provide services in compliance with TCYC performance standards established to assure children and families of high quality services. Standards include timely access, assessment of parent satisfaction and actual provision of authorized services. These performance standards are set forth below in sections 5.11.1-5.11.3. Agencies are required to provide periodic reports to DHS regarding their level of compliance with performance standards. Agencies that do not meet established performance standards will be required to provide corrective action plans. Consistent failure to meet performance standards may result in provisional certification status.

### 5.11.1 Timeliness of Service Provision

In order to meet the needs of children and families, TCYC services must be provided in a reliable and timely manner given the following requirements:

- 1) A CEDARR referral must result in the provider-agency establishing an intake appointment with the child and parents. Families must be offered a specific appointment date within two (2) weeks of referral. This must be documented in the clinical record.
- 2) The purpose of the intake appointment(s) is to review the CEDARR Family Care Plan with the family, introduce the family to the child or youth care program and to discuss the agency's approach to supporting successful participation in that setting for the child. This is an initial meeting to establish a working relationship with the child's family. As such, it is an opportunity for parents to ask questions regarding the provider-agency's TCYC program, parental involvement, and expectations. Parents are to be provided with written information regarding TCYC and related policies such as client rights, and grievance procedures.
- 3) If the intake appointment is positive and the family wants to pursue TCYC for this child, the intake appointment is followed by a more detailed assessment and development of a Therapeutic Integration Plan proposal. The provider-agency must develop and submit the Therapeutic Integration Plan to the CEDARR Family Center for review within four (4) weeks of the initial intake appointment. This Therapeutic Integration Plan is focused on goals and objectives aimed at successful participation, as recommended by the CEDARR Family Care Plan.
- 3) When developing a Therapeutic Integration Plan for a CEDARR Family Center review, the provider-agency must be able to start the plan within four weeks of the authorization that will be provided by the CEDARR Family Center. The Therapeutic Integration Plan must identify the strategy of the provider agency to staff the proposed plan.

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### **5.11.2 Parent Satisfaction**

Routine and consistent parent feedback is an important aspect of quality assurance. TCYC provider-agencies shall design and administer survey instruments to generate information for activities related to parent satisfaction with provider-agency services, accessibility, availability, and overall level of satisfaction. Section 6.6.5 provides further elaboration and direction. Parent/guardian information is strictly confidential; however summary results are to be presented to the State.

### **5.11.3 Provision of Authorized Services**

Fully certified provider-agencies will be in compliance with the Certification Standard and meet performance standards. The performance standard for this Certification Standard is that a TCYC provider-agency must not exceed the appropriate staff to child ratios as set forth in the certification standards. If these standards are not maintained, agency performance will be reviewed and a corrective plan from the provider agency will be required. Continued failure to comply may result in the provider agency receiving a provisional certification status.

## **6.0 CERTIFICATION STANDARDS**

### **6.1 Requirements for Organization of Delivery of Service**

An applicant for certification must demonstrate that it brings to this program a sound combination of developmentally appropriate approaches, management skills, experience, and the capability to reliably provide TCYC.

Sections 6 and 7 identify the requirements that must be addressed in a certification application. Applicants are to describe their approach to meeting these requirements. Further guidance as to how to complete the application is included in Attachment A, Application Guide.

### **6.2 Agreement to Accept Appropriate Referrals**

Certified TCYC provider-agencies will be expected to accept all appropriate referrals of Medicaid enrolled children who are determined to be eligible for TCYC by a CEDARR Family Center, and to provide services on a timely basis as defined in Section 5.11.1 of these Certification Standards. In rare instances, provider-agencies may feel they are unable to submit a Therapeutic Integration Plan when they determine that their agency cannot meet the child's needs. In such an event, the assessment will be forwarded to the CFC and DHS documenting the reasons the TCYC provider agency cannot meet the child's needs. Consistent refusal of referrals will result in comprehensive review of the provider agency's certification status.

#### **6.2.1 Provision of Authorized Services**

DHS regards the effectiveness of intervention to be related to the availability and continuity of staff. It is the responsibility of the provider-agency to ensure that there are substitutes available

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and these newly assigned workers are ready to provide child specific intervention by arranging for a period of child specific orientation. The Clinical Supervisor is responsible for overseeing child specific orientation. The Clinical Supervisor, as identified in the Therapeutic Integration Plan, provides this orientation.

Consistency of care is considered fundamental to the care of children with special health care needs. TCYC provider-agencies may experience staff turnover and need to recruit new Therapeutic Integration Specialists to implement Therapeutic Integration Plans. A newly assigned staff person is expected to be knowledgeable about a child's condition and intervention approaches. The child specific orientation should occur prior to or concurrently with the child's entry into the setting. It is expected to last at least 30 minutes and be documented in the child's clinical record. The orientation should assure that the specialist is prepared to carry forward the goals, objectives and techniques of the child's specific Therapeutic Integration Plan.

### **6.3 Family Centeredness, Client Rights and Ethical Standards of Practice**

#### **6.3.1 Family Centeredness**

TCYC provider-agencies must incorporate key components of family-centered care into their philosophy, service program, operations and education. Applicants must demonstrate the manner in which important principles of family-centered care are part of their approach to services. Areas of program policy shall include, but are not limited to, the following:

- 1) Established arrangements for ongoing communication with and participation of the family. This means daily reports with specific content that addresses the child's progress toward meeting the goals of the Therapeutic Integration Plan. This may include daily written reports, regularly scheduled meetings with families, etc.
- 2) Policy setting forth the family involvement in care planning.
- 3) Policies setting forth emphasis on family-centered service outcomes.
- 4) Description of service arrangements flexible enough to meet special and individual needs.
- 5) Demonstration of approaches to assuring that families are encouraged to voice concerns and provide input

#### **6.3.2 Client Rights and Family Service**

Families must be informed of their rights and responsibilities, the expectation for their participation in Therapeutic Integration Plan development and implementation, and problem-resolution processes prior to the establishment of a Therapeutic Integration Plan. The TCYC must inform families regarding the process for registering concerns, complaints and grievances. The TCYC provider-agency shall have an established approach to ensure that this communication is maintained throughout the course of care. In this regard, the provider-agency

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shall have policies, procedures and related records to ensure focus on customer service, solicitation of family input, documentation of and response to complaints, and prompt complaint resolution. This means being able to address complaints from parents or recipients of TCYC, CEDARR Family Centers or DHS, as well as staff working for the agency.

A parent or guardian has the right to terminate TCYC at any time during an authorized course of treatment.

Written materials shall be provided to families identifying those unusual circumstances under which a Therapeutic Integration Plan will be discontinued by the provider agency. Because termination of a child from participation in therapeutic child or youth care may have significantly negative effects upon the family, a provider agency shall make all reasonable efforts to minimize this possibility. These efforts should include the following actions:

The provider agency shall communicate with the family the reasons for requested termination and communicate with the CEDARR Family Center.

The provider-agency must have written policies to facilitate an orderly transition of care, and/or follow-up or referral for services. These policies shall include:

- Written notification of termination shall be sent to the child's family, DHS and CEDARR Family Center prior to discontinuing TCYC.
- Reasons for discontinuing must be stated.
- Alternative resources and/or referrals must be recommended and forwarded to the CEDARR Family Center.
- Transition notice and transition plan must be submitted to the child's family, DHS and the CEDARR Family Center.

The provider-agency shall have an established approach to ensure that client rights are clearly stated and communicated. Practices shall include maintaining written policies and procedures, as well as materials provided to families at the onset of care and periodically. Written materials shall also be provided to families identifying the circumstances under which a Therapeutic Integration Plan will be discontinued.

### **6.3.3 Ethical Standards**

Clearly articulated Principles of Ethical Care and Professional Conduct must be publicly posted. Protocols will identify standards of ethical practice for staff. The latter shall include, but will not be limited to, the following issues:

- Grievance policies and procedures;
- Discipline Policies

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- Written description of services provided

#### **6.4 Coordination and Communication with CEDARR Family Centers**

All CEDARR Family Centers provide information and support services to families of children with special health care needs (CSHCN). Linking families to appropriate resources (e.g., clinical specialists or services) and providing time-limited care coordination are central aspects of the CEDARR system of care.

From the outset, the CEDARR Family Center works with the child and family to assess current circumstances, strengths, continuing needs and reasonable next steps. Upon completion of an Initial Family Assessment (IFA) and clinical specialty evaluations, if indicated, a CEDARR Family Care Plan (FCP) is developed. The plan may include CEDARR Direct Services and Supports. TCYC may be one of these CEDARR Direct Services, if the family concurs. In this case, the CEDARR Family Center will provide the family with information about certified TCYC agencies. The family and/or the CEDARR Family Center will schedule an intake appointment with the agency of the family's choice. The CEDARR Family Center will help coordinate arrangements for all CEDARR Direct Services and Supports.

It is anticipated that in the majority of cases, the CEDARR Family Center will continue to work with the family to support efforts to access needed services, to track receipt of services and progress in meeting stated goals and outcomes. CEDARR Family Centers are responsible with the family to determine the types of service, intervention needed, the required outcome of services, the appropriate approach to service intervention, and to recommend to DHS the authorization of service type, intensity, and duration.

The TCYC provider-agency has the obligation to maintain communication with families and CEDARR Family Centers. Based on these communications, information is provided to the family about any projected waiting period that could delay the start of services. With this information, the family is better able to exercise informed choice regarding its preferred provider. The TCYC provider-agency must comply and adhere to communication and coordination requirements with CEDARR Family Centers.

A provider-agency seeking to offer TCYC must describe in its application its processes to ensure coordination and communication with all CEDARR Family Centers. An applicant must demonstrate that it can work with CEDARR Family Centers and that it understands the role of the CEDARR Family Center in working with families. The TCYC provider-agency must have established protocols for communication with a CEDARR Family Center in the following areas:

- 1) Accepting referrals and information
- 2) Providing Therapeutic Integration Plan proposals to the CEDARR Family Center for its review within certification standards timelines

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- 3) Providing information to the CEDARR Family Center regarding progress or lack of progress in meeting goals.
  - 4) Informing the CEDARR Family Center in writing of changes in the child's needs or the ability of the TCYC provider-agency to meet direct services hours, goals and objectives identified in the CFC Family Care Plan and the Therapeutic Integration Plan.

The provider-agency must include in its application a letter of understanding with each CEDARR Family Center regarding these processes.

#### **6.4.1 Initial Referral to a CEDARR Family Center**

Initial referral to a CEDARR Family Center of potential candidates for TCYC may occur in one of several ways:

- Family referral
- Referral from a medical provider (e.g., primary care provider, other medical specialist, or mental health clinician, etc.)
- Referral from a RItE Care Health Plan
- Community referral (e.g., community mental health center, school, EI, CASSP, DCYF)
- Hospital or residential level of care referral
- Referral from a TCYC provider

All referrals for TCYC will be evaluated by a CEDARR Family Center. With the consent of the family, the CEDARR Family Center will engage the family in evaluating the needs of a child, which could result in a recommendation for TCYC. The TCYC provider-agency must work directly with all CEDARR Family Centers regarding

- prior authorization of new services,
- renewal of services
- communication of progress

All aspects of TCYC will be coordinated through a CEDARR Family Center. The CEDARR Family Center will make recommendations for authorization to DHS. The family may engage with their choice of CEDARR Family Centers. Applicants must

- describe their understanding of these arrangements,
- describe how they will interact with CEDARR Family Centers
- report on their initial contacts with CEDARR Family Centers (See Appendix 10).



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## **6.4.2 CEDARR Family Center Initial Family Assessment (IFA) and Basic Services**

The goal of the IFA is to develop a working profile of the family. The assessment includes:

- an assessment of urgency,
- a developmental and diagnostic history (including physical health, behavioral health and cognitive development)
- an analysis of current interactions with the care system (e.g., RItE Care, pediatrician, specialist, hospital, or other provider)
- involvement with other programs (e.g., Early Intervention, CASSP, or school programs)
- family strengths, needs and supports; knowledge of or linkage with advocacy groups or professional associations
- current insurance status and needs; and potential eligibility for various public programs or community supports.

## **6.4.3 CEDARR Family Center Care Plan**

On the basis of the IFA, the Family Care Plan (FCP) will be developed in concert with the family. The Family Care Plan may result in possible referrals and/or services, which could include but are not limited to:

- Therapeutic Child and Youth Care
- Home-Based Therapeutic Services
- Private Duty Nursing
- Certified Nursing Assistant
- Personal Assistance Services and Supports (when available)
- Community based supports (Peer, family, religious, recreation, primary or specialty care)

The Family Care Plan for an individual child may include a combination of these and/or other services.

When the clinical appropriateness criteria for TCYC appear met and the family has selected a preferred provider-agency of these services, the CEDARR Family Center will make a written referral to a certified TCYC provider-agency of these services. The referral will include:

- 1) Initial determination of needs and characteristics of the child:
- 2) Projected number of hours per week of TCYC

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- 3) Expected duration for the service (Note that six months is the maximum period for a Therapeutic Integration Plan before Plan Review, Revision and Reauthorization is required).
  - 4) Physician's order for nursing services, if indicated

#### **6.4.4 CEDARR Family Center Certified TCYC Plan**

The referral from the CEDARR Family Center provides the initial information noted above. The CFC will provide materials from its own assessment to avoid duplication of effort by the TCYC provider-agency. The CFC will make recommendations for intensity of therapeutic integration hours. Next, the Clinical Supervisor of the TCYC provider-agency, and will include work with the family and perform a more focused assessment directed toward determining the specifics of the Therapeutic Integration Plan and the appropriate arrangements for actual provision of services. This Therapeutic Integration Plan will detail goals and objectives, schedule of service, communication plans with the family and other relevant considerations. Provisions regarding communication with the family must be included in the Therapeutic Integration Plan to assure consistent communication and to enhance the transfer of learning from the child or youth care setting to the home. The Therapeutic Integration Plan is submitted to the CEDARR Family Center for review.

The CEDARR Family Center has the authority to approve, reject or request modification to the provider-agency's proposed Therapeutic Integration Plan. Once approved by the CFC, its recommendation for authorization is then transmitted to DHS and to EDS. Based on DHS approval it is included in the finalized Family Care Plan.

#### **6.4.5 DHS Fair Hearing Process**

If a child's parents or guardian objects to the decision of the CEDARR Family Center regarding the review of the therapeutic integration plan or in regard to the authorization of a plan, they can request a hearing through DHS. An Administrative Fair Hearing allows for testimony to be presented from all concerned parties (See Appendix 11). In turn, the Hearing Officer renders a written decision. Upon completion of this process, the prior authorization necessary for claims to pay may be adjusted based on the hearing decision.

Rules and procedures for requesting a Fair Hearing are as follows with related information provided in Appendix 11:

- 1) The recipient's parents or guardian will receive a written copy and notification of authorization for the plan or a denial. If this is the case, and the parents or guardian disagree, they have ten (10) days from the date of the denial to file a request for a Hearing.
- 2) If the denial is for the renewal of the Therapeutic Integration Plan and the request for a fair hearing is received by DHS within ten days, there will be no modification to the plan

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until the conclusion of the Hearing. During this time, the provider-agency may submit claims for payment of services, as the proposed Therapeutic Integration Plan in dispute remains in effect.

- 3) If a request for a fair hearing is received after ten days but within thirty days, the therapeutic integration plan will stand until the conclusion of the Hearing. Claims will be paid in accordance with prior authorization.
- 4) Hearing decisions may be appealed to the Superior Court within 30 days of the date of the hearing decision pursuant to Rhode Island General Laws 42-35-1 et seq.

## **6.5 Strength Of Program Approach: Process of Care and Management of Clinical Services**

The applicant must demonstrate that it brings a sound combination of experience and skills to be certified as a TCYC provider-agency. The agency will use written standards of care to describe the process by which TCYC services are planned, delivered, monitored and evaluated. There will be evidence of initial and on-going involvement of the family. The applicant will ensure that therapeutic integration staff have appropriate competencies, educational preparation, and experience to engage in the delivery of TCYC services. Through their application, interested parties are extending their commitment to providing their high quality care to often neglected groups of children, i.e. children with special health care needs.

In describing its program, the applicant will specifically address 6.5.1 Process of Care and 6.5.2 Management of TCYC Services.

### **6.5.1 Process of Care**

Process of care pertains to the clinical protocols and practice that guide the delivery of services. The child and/or youth care provider will demonstrate that the care process is systematically organized and grounded in sound principles. In section 6.5.1, the applicant will describe its model and policies and procedures for the provision of TCYC. In doing so, the applicant should address each subsection.

#### **6.5.1.1 Therapeutic Approach and Clinical Guidelines**

Guidelines should be submitted in the application that will demonstrate diversity and flexibility while promoting the best possible outcome for each child. These guidelines must address Screening and Intake, Assessment and Plan Development, Therapeutic Integration Plan Implementation, and Therapeutic Integration Plan monitoring and modification. Written standards, policies and procedures will be in place for all aspects of TCYC.

The applicant must provide documentation of its philosophy and approach to successful inclusion and participation of children with special health care needs with peers who are typically developing in the child or youth care setting. This should include information about methods to

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insure that these children and youth are not isolated from their peers who are typically developing and are interacting and participating with them in a socially meaningful manner. Professionally recognized guidelines may be included along with identification of how adherence to such guidelines is systematically monitored.

#### **6.5.1.2 Screening and Intake for TCYC**

Applicants must have an organized process for handling referrals, for screening and intake, and for determining the appropriateness of the services of their particular agency for a child and family.

Screening and intake must be based on written policies and procedures that clearly define admission criteria which are consistent with the appropriateness criteria contained within these standards and which reflect the agency's plan for delivering therapeutic integration services. These policies must ensure that contact with a family respects the family's privacy, and is conducted in a culturally sensitive and family-centered manner.

The application for certification must include written policies and procedures for addressing the following:

- 3) Managing referrals.
- 4) Screening and intake.
- 4) Eligibility and admission criteria.
- 5) Management of direct services.
- 6) Management of waiting lists and communication with families.
- 6) Assisting families not eligible for TCYC by providing specific information as to why the TCYC agency feels that the services are not appropriate for the child

A documented written record of the intake is to be maintained.

#### **6.5.1.3 Assessment and Therapeutic Integration Plan Development**

The applicant shall describe the protocol to be used for the therapeutic integration assessment. This shall include identification of the approach to the specific problem(s) to be addressed which serve as barriers to full participation of the child or youth in the care setting. Various aspects of the assessment shall be identified (e.g., communication with the CEDARR Family Center, parent interview, child observation, conversations with school representatives, collaboration with other health care providers, and review of past evaluations). Components of the Assessment shall include:

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- How the appropriateness criteria are met
  - Specific obstacles that may be encountered; history of unsuccessful experiences with child care, if any
  - Areas of specific support/intervention for successful participation and strengths that can be built on

Written parental consent will be obtained for all requested documentation. All records shall be maintained to ensure their security and confidentiality.

The CEDARR Family Center maintains information on the child's diagnosis (DSM IV or ICD-9), who made the diagnosis, the basis for the diagnosis, when the diagnosis was made, and its current status. The CEDARR Family Center maintains updated treatment information for any period of authorized care.

This information, as well as other information gathered in the Initial Family Assessment, will be provided to the Clinical Supervisor, as needed, to aid in the Therapeutic Integration Assessment and Plan Development.

The provider agency will adhere to appropriateness criteria for admission to TCYC for that particular agency.

#### **6.5.1.3.1 Therapeutic Integration Plan Development**

The applicant will describe the provider agency's specific protocol for the development of the Therapeutic Integration Plan. The protocol will identify the provider-agency's overall approach and address each of the following:

- 1) The identification and prioritization of intervention goals and objectives for inclusion shall be clearly based on the assessment and directed toward optimal inclusion of the child in care. Goals, objectives and interventions should be realistic, specific and measurable. These should be related to the typical daily activities at the agency for typically developing children.
- 2) A brief description of interventions based on the child's strengths, whenever possible, for each identified problem shall be included. This means defining intervention methods (e.g., social reinforcement, social stories, modeling, cueing, supports, etc.) linked to clearly defined goals.
- 3) The level of communication with the parent must be identified in the Therapeutic Integration Plan. The plan may include a parent consultation component (e.g., behavior modification techniques, conflict resolution, information on child development and supports).

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- 4) The Therapeutic Integration Plan shall meet the criteria for Family-Centered Care (See: Section 1.4).
  - 5) The parent/guardian/legal custodian must participate in the development of and sign the proposed Therapeutic Integration Plan.
  - 7) The number of weekly intervention hours shall be clearly explained and justified in detail in the Therapeutic Integration Plan.
  - 8) The Therapeutic Integration Plan shall indicate the anticipated duration of the plan and the method for measuring progress towards obtaining the stated goals including relating these goals to the discharge criteria.
  - 9) The Therapeutic Integration Plan shall include the details of coordination with other services the child may be receiving, e.g. Special Education services.
  - 9) The Therapeutic Integration Plan must specify the frequency and method of communication with the CEDARR Family Center.

Goals must be written in behavioral terms with well-defined objectives. Goals are broad, generalized statements about what is to be learned within the 6 month period of treatment. Objectives are specific, measurable, short-term, observable behaviors.

Integration plans must also include the plan for clinical supervision. It is expected that the licensed clinician or certified special educator who developed the plan will serve as the Clinical Supervisor for the direct services provided by the Therapeutic Integration Specialist.

#### **6.5.1.4 Therapeutic Integration Direct Services**

Therapeutic Integration Direct Services are designed to provide the supports and services needed to achieve successful participation in child or youth care centers. They include the following two components:

- a) Direct services delivered by a Therapeutic Integration Specialist (paraprofessional) and provided in the context of the center.
- b) Clinical supervision of this integration plan should include observation of the Therapeutic Integration Specialist while he/she is working in the center with the child and implementing the Therapeutic Integration Plan, and should include the child's response to the Plan interventions. Supervision should also include direct instruction and modeling intervention techniques, as well as helping the Therapeutic Integration Specialist with other issues that may arise in providing the direct services.

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It is necessary to demonstrate how the child's progress is used during clinical supervisory sessions and parent communications to inform the delivery of care. It must also be evident that data is appropriately maintained and reviewed for determining future TCYC needs.

The services of the Clinical Supervisor must be documented in writing with respect to the specific child's plan, date, duration of supervision, name of the Therapeutic Integration Specialist who received supervision, and reflect sufficient content to substantiate the delivery of this service. It is expected that the Clinical Supervisor is the same person who conducted the assessment and developed the therapeutic integration plan.

The applicant shall describe how it will provide effective, efficient, high quality services on a timely basis. The applicant must ensure that a child's assessment and plan is completed in a timely manner consistent with certification expectations:

#### **6.5.1.5 Therapeutic Integration Plan Modification and Renewals**

The applicant must describe its procedures for Therapeutic Integration Plan monitoring and modification of intervention throughout a course of care. Resources (i.e., staff and staff responsibilities) and processes (clinical supervision) must be identified to ensure that documentation is collected and used to inform progress toward full participation of the child or youth in the care setting during an approved course of TCYC.

It is recognized that success in achieving objectives will vary for many reasons. However, when progress falls significantly below expectations of the provider or family, or there is evidence of regression during a course of TCYC, changes and modifications to interventions that result from this must be described and implemented. The provider must demonstrate that this takes place throughout a course of care.

When seeking re-authorization of TCYC, the TCYC provider/clinical supervisor must demonstrate how TCYC can maximize the goals to enable full and safe integration of the child in the care setting. This means reviewing methods of intervention and ensuring that best practices are followed.

The TCYC provider-agency must agree to provide a summary of the child's response to TCYC to the child's primary health care provider, the Rite Care Health Plan, the CEDARR Family Center and others upon written request from the parent or guardian.

#### **6.5.2 Management of TCYC Services**

Management of care specifically pertains to the way in which services are organized with primary attention to staffing structure and supervision. The applicant must demonstrate a sound organizational approach to ensuring the provision of effective, timely and high quality child/youth care services. Critical for success of creating and sustaining an inclusive setting will be the organizational approach taken. This is true for both the development of the specific service and to its integration within the overall structure and culture of the setting. To be effective,

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TCYC providers need to work in concert with teachers and teacher assistants who have primary responsibility for the child and youth care services already in place. Teachers and teacher assistants need to understand and support the objectives of TCYC to promote success. Administrative leadership will be key. Certified providers will demonstrate that the care process is systemically organized and grounded in sound principles. Refer to section 7.4 for additional requirements. In this section, the applicant will describe its organization and management model for TCYC.

It is incumbent upon an applicant choosing to offer TCYC to provide evidence of agency licensure, i.e. DCYF, credentials of the licensed health care professional or certified special educator, and identify any agency accreditation provided by national governing bodies (e.g., NAEYC). Therefore, the applicant must attach copies of appropriate licensure(s) and agency accreditation, when applicable.

The following areas must be addressed:

#### **6.5.2.1 Roles and Scope of Practice**

The work of the TCYC team (child or youth care agency, licensed health care professional or certified special educator, Therapeutic Integration Specialist and nurse, if indicated) must be systematically organized with clear delineation of the staff roles, reporting relationships and supervision. This must also pertain to how it fits into the organization as a whole. Detailed job descriptions must be provided for the licensed health care professional or certified special educator, Therapeutic Integration Specialist and TCYC nurse. Protocols must include clear delineation of the role and scope of practice, including working in collaboration with the other child care staff in such areas as:

1. Scope of practice and supervision
2. The ways in which clinical supervision is carried out, and ratio of supervisor time to Therapeutic Integration Specialist intervention time
3. Staff evaluation protocols
4. Therapeutic Integration Plan design, implementation monitoring, evaluation and Therapeutic Integration Plan modification.
5. Coordination and communication with family.
6. Coordination and communication with CEDARR Family Center and communication with other service providers as appropriate.

In TCYC it is assumed that the Therapeutic Integration Specialist will be a regular staff member (full or part-time) employed by the child care agency. The Director or Head Teacher will provide



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administrative supervision. Oversight of implementation of the Therapeutic Integration Plan will be the responsibility of the clinical supervision.

An organizational chart must be provided which identifies the specific individuals who fill identified positions and list credentials. Personnel for TCYC must meet all applicable State licensure and certification requirements. Position job descriptions for the Therapeutic Integration Specialist, Clinical Supervisor and Nurse must be provided and address such areas as:

1. Reporting relationships
2. Functional tasks and performance expectations.
3. Required skills, training, and experience.
4. Licensure or certification qualifications, if applicable

### **6.5.2.2 Clinical Supervision**

The Clinical Supervisor will have responsibility for overseeing the Therapeutic Integration Plan for all participating children and the TCYC certified agency. Clinical Supervision of Therapeutic Integration Specialists must occur throughout a period of authorized intervention. Policies and procedures must be in place to ensure the reliability and availability of supervision by qualified personnel. This means:

- 1) The Clinical Supervisor must have appropriate credentials and meet qualifying standards to provide supervision as noted in section 6.5.2.3.
- 2) Written policies and procedures that demonstrate a clear clinical supervisory structure that guides the overall approach to inclusion within the agency, the delivery and implementation of interventions, supervision of TCYC workers (i.e., specialized interventions and intervention support), and management of services, including assessment of progress and modifications to Therapeutic Intervention Plans.
- 3) Defining the ratio of supervisor's time to TCYC staff showing the ways in which clinical supervision is provided in accordance with certification standards.
- 4) Protocols identifying team meetings, team participants, and process for periodic assessment and Therapeutic Integration Plan revisions as appropriate.
- 5) Methods of administrative supervision provided by the Director/Head Teacher.

### **6.5.2.3 Staffing and Staff Qualifications**

It is the responsibility of a provider-agency to conform to DHS TCYC certification requirements regarding staff credentials, training, personnel management, and guidelines as well as DCYF licensing regulations. In order to provide Therapeutic Integration Services, the provider-agency shall demonstrate that it has the arrangements to meet the specific staffing requirements for the Therapeutic Integration Specialist, Clinical Supervisor, and the TCYC nurse, when appropriate.

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The applicant must therefore give written assurances that this staffing standard will be provided and maintained as a requirement for receiving and maintaining certification.

With respect to continuing education, the provider-agency shall have policies and procedures in place for all staff consistent with DHS certification and DCYF licensure requirements. This requires that:

- 1) Licensed health care professional or certified special educators providing clinical supervision conform to DOH or DOE continuing education requirements according to respective disciplines. Therefore, the applicant is directed to consult with Department of Health guidelines for licensure of individual health care professionals and the Department of Education for Certified Special Educator.
- 2) Child care staff, i.e. Therapeutic Integration Specialist shall complete a minimum of 2 hours per month or 20 hours per year of continuing education related to the skills and knowledge necessary to provide therapeutic integration services for children and youth with special health care needs in child and youth care. This may be achieved through formal in-service training programs or college level coursework specific to this field. The State reserves the right to require certain additional training appropriate to this service.

An employment background check, Background Criminal Investigation (BCI) and Child Abuse Neglect Tracking System (CANTS) as required by DCYF is needed of all potential staff. The provider-agency must have policies in place to ensure that these screenings take place. In addition, the following requirements must be met for TCYC staff.

#### **6.5.2.3.1 Therapeutic Integration Specialist**

##### **A. Relevant experience and training**

- 1) Demonstrate competency to work with children with special health care needs
- AND
- 2) Be at least 19 years of age; have a high-school degree or equivalent, and two years of supervised experience working with children with special health care needs, or Child Development Associate Certificate
- OR
- 3) Have an Associate's degree in human services (e.g., psychology, counseling, child development, education, nursing)

#### **6.5.2.3.2 Clinical Supervisor**

##### **A. Licensure**

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Must be a Rhode Island licensed health care professional or certified special educator with current licensure/certification as one of the following<sup>3</sup>:

- Licensed independent clinical social worker (LICSW)
- Registered nurse with a Masters degree
- Licensed psychologist
- Marriage and Family Therapist
- Mental Health Counselor
- Special Education Teacher with a Masters degree and Certification from the Department of Education

**B. Relevant experience and training**

One year of experience that can demonstrate that the Clinical Supervisor has the ability to design and oversee programs that support inclusion of children and youth with diverse types of special health care needs in natural settings. Key to this ability would be an understanding of inclusion strategies and need for participation by children and youth, knowledge of various kinds of disabilities and how they would affect the process of inclusion, and the skill to integrate information from various specialists into a Therapeutic Integration Plan.

**6.5.2.3.3 Nurse**

**A. Licensure**

Must be a Rhode Island registered nurse

**B. Relevant experience and training**

One year of experience providing pediatric nursing care.

**6.5.2.3.4 Agency Orientation and Training**

All staff providing TCYC services shall be provided with a general orientation to the provider-agency with respect to its mission, policies and procedures, administrative structure, training, and other relevant information. They shall also provide child and youth specific orientation for each new child or youth with special health care needs who enter into the setting. The provider-agency must have policies and access to programs for orientation, training of new staff, continuing education and professional development that fully meet the Certification Standards and DCYF licensing regulations as specified in the following section. Staff are required to participate in these activities, as specified by the individual's position and job description.

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<sup>3</sup> In exceptional circumstances, other clinical supervisory arrangements may be accepted if they substantially meet the licensure and training requirements as specified in this section (e.g. matriculated advanced graduate students, interns, residents or fellows under the supervision of a licensed clinician).

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Personnel files shall contain documentation of the training programs staff have completed. Provider-agencies must have a written program for orientation of all new staff and in-service training as required by DCYF. Provider-agencies shall annually determine staff training needs and develop a written plan and schedule of staff training. It is anticipated that needs can be met through the use of already existing resources, e.g. Childspan, Rhode Island's statewide child care training system.

#### **6.5.2.3.5 Preparation of Staff**

The provider-agency shall delineate the requirements used to ensure that all clinical supervisors, Therapeutic Intervention Specialists and nurses are fully qualified to implement all aspects of a Therapeutic Integration Plan before engaging in the delivery of care to a child. As a condition of employment and on a case-by-case basis, Therapeutic Integration Specialists shall have basic knowledge and skills as specified in Section 5.4, Table 3. In addition, basic training for all Therapeutic Integration Specialists shall include, but not be limited to the following:

##### **Clinical Training**

- Child Development and Knowledge of children who are not developing typically
- Knowledge of various diagnostic categories of children with special health care needs
- Child Abuse recognition and reporting requirements
- Inclusion strategies for children and youth with special health care needs

##### **Medical Training**

- A valid certification in first aid, including management of a blocked airway and rescue breathing

The following training topics under Therapeutic Integration Services Specifics (see below) shall be provided prior to a Therapeutic Integration Specialist delivering services to a child:

- Client rights
- Ethics and confidentiality
- Reporting procedures and documentation requirements
- Overview of the Therapeutic Integration Plan

In addition to training offered locally, these topics can be addressed through the use of national resources, e.g. the National Child Care Information Center.

#### **6.6 Timeliness of Service, Other Access Standards**

Fully certified providers will be in compliance with the certification standards and meet performance standards for the timeliness of services provided. There are performance standards for timeliness of services provided to referred clients.

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## **6.6.1 Timeliness Standards for New Referrals**

The TCYC Provider Agency must meet the following timeliness performance standards.

### **6.6.1.1 Intake Appointment**

The performance standard is each TCYC provider agency must conduct an intake appointment for at least 90% of those requesting an appointment within 2 weeks of referral from each CEDARR Center. Conducting less than 90% of intake appointments within this prescribed timeframe may result in provisional certification status. This is to assure that families will be contacted in a timely manner and that backlogs are avoided.

### **6.6.1.2 Therapeutic Integration Plan Submission**

The performance standard is that a TCYC provider agency must submit at least 90% of plans for those for whom therapeutic integration services are appropriate to CEDARR Family Centers for approval within 4 weeks of written referral. Submitting less than 90% of new Therapeutic Integration Plans within this prescribed timeframe may result in provisional certification status. Submitting plans within 4 weeks assures that services can begin promptly after review by the CEDARR Family Center and authorized by DHS.

### **6.6.1.3 Initiation of Direct Services**

The performance standard is a TCYC provider-agency must initiate direct services for at least 90% of new clients within 4 weeks of Therapeutic Integration Plan authorization. Initiating direct services for less than 90% of new clients within this prescribed timeframe may result in provisional certification status.

## **6.6.2 Timeliness Standards for Renewing Cases**

The performance standard is a TCYC provider-agency must submit for reauthorization all (100%) Therapeutic Integration Plans requiring renewal at least 30 days prior to expiration of an existing approved plan. Submitting less than 100% of plans for reauthorization within the prescribed timeframe may result in provisional certification status. Meeting this standard will avoid disruption in payment for services.

## **6.6.3 Timeliness Standards for Therapeutic Integration Plan Review Process**

Provider agency cooperation is required throughout the CEDARR Family Center review of the proposed Therapeutic Integration Plan. Should a reviewer require clarification or additional information, the TCYC provider-agency is required to respond in writing to the reviewer within nine (9) calendar days.

The performance standard is that additional information requested by CEDARR Family Centers in the process of Therapeutic Integration Plan review and reauthorization will be provided within

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nine calendar days for all (100%) Therapeutic Integration Plans for which questions arise throughout the reauthorization process. Replying to less than 100% of requests for information during the reauthorization review process within the prescribed timeframe may result in Provisional Certification status.

#### **6.6.4 Hours of Service**

TCYC must be available to families on a continual basis throughout a period of authorized services. The applicant shall define its hours of operation, which can include days, evenings, and weekends. Families must be informed of hours of operation. It is required that the applicant provides care on a year round basis.

##### **6.6.4.1 Continuity of Care**

It is the responsibility of the TCYC provider-agency to address continuity of care to minimize disruptions in care (i.e., holidays, staff vacations, sick time, etc.). In the application, the provider-agency must demonstrate its process and procedures for maintaining continuity of care and inform parents of this responsibility. With respect to multiple Therapeutic Integration Specialists providing interventions, the provider-agency shall limit the number of specialists assigned to a given case to ensure continuity and consistency in interventions, as well as assure substitute integration specialists are available.

#### **6.6.5 Measures of Parent Satisfaction**

Parent satisfaction surveys must be conducted at the completion of each authorized integration plan. When multiple children within a family are receiving services, one survey is needed for each child receiving services.

The format and content of the measurement tool is the responsibility of the provider-agency. Areas of interest to DHS include, but are not limited to;

- a) Sensitivity to family centeredness and cultural competencies;
- b) Availability of Clinical Supervisor
- c) Progress made during plan implementation (e.g., participation in child care and quality of life outcomes);
- d) Communication with family and others (e.g., CEDARR, medical professionals, school personnel);
- e) Staff availability, promptness and actual delivery of authorized hours;
- f) Professionalism of staff and services (i.e., accounting of complaints, compliments, and grievances).

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It is recommended that surveys include both quantitative and qualitative feedback from parents. Survey results will be analyzed, and reported to DHS. Further clarification regarding content and/or reporting will be provided by DHS once the certification process has been completed.

## **6.7 Service Monitoring and Reporting**

The TCYC Provider Agency must comply with the following service monitoring and reporting requirements. See Appendix 12 for additional information regarding reporting requirements.

### **6.7.1 Quarterly Reports**

Provider agencies will be expected to report required data for each calendar quarter on the last business day of the month following the end of each calendar quarter (i.e., on April 30 provider-agencies will report data regarding clients newly referred and requiring reauthorization during the period of January 1 - March 31). The first Quarterly Report is due following the completion of the second calendar quarter following DHS certification of the provider agency.

Provider Agencies are required to submit the following reports on a quarterly basis:

#### **Report 1 – Report on Compliance with required staff to child ratio**

The purpose of this report is to determine compliance with the required Therapeutic Integration Specialist to child/youth ratio.

#### **Report 2 - Timeliness of intake appointments for new referrals**

The purpose of this report is to monitor the percentage of initial intake appointments that occur within 2 weeks of a written referral from a CEDARR Family Center.

#### **Report 3 - Timeliness of new TCYC Plan submissions**

The purpose of this report is to monitor the percentage of Therapeutic Integration Plans that are submitted to a CEDARR Family Center for review within 4 weeks of an initial intake appointment.

#### **Report 4 - Timeliness of direct service initiation**

The purpose of this report is to monitor the percentage of children for whom therapeutic integration services are initiated and fully staffed within 4 weeks of Therapeutic Integration Plan authorization.

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## **Report 5 - Timeliness of renewing Therapeutic Integration Plans**

The purpose of this report is to monitor the percentage of Therapeutic Integration Plans that propose an additional period of TCYC services that are submitted for review at least 30 days prior to the expiration date of an existing Therapeutic Integration Plan.

### **6.7.2 Annual Reports**

Provider Agencies will also be required to provide reports on an annual basis. Annual reports are to be submitted 30 days after the close of the state fiscal year, July 1 – June 30) The first annual report is due at the close of the fiscal year in which DHS certifies the provider agency.

Provider-agencies are required to submit the following reports and documents on an annual basis:

- Documentation of trainings attended by Therapeutic Integration Specialists and Clinical Supervisors
- Written documents provided to families regarding their rights and responsibilities and documents demonstrating family-centeredness
- Summary of family satisfaction survey methods and results
- Summary report of all complaints received and logs of timeliness of complaint resolution

### **6.7.3 Additional Service Monitoring and Reporting**

DHS may also request additional reports, documentation, and site visits, as necessary to monitor compliance with these Certification Standards and services provided by the provider-agency.

## **6.8 Record Keeping Requirements**

The provider agency must describe its policies and procedures for record keeping. This must demonstrate the understanding that a clinical record for each child must be maintained which records activities performed in the implementation of the Therapeutic Integration Plan. This includes daily identification of the units of service provided and the person who provides those services (performing provider). Services billed shall correspond with those recorded in the clinical record and shall not exceed those delineated in the approved Therapeutic Integration Plan.

Appendix 12 (Documentation Guidelines) provides further detail for compliance with Medicaid regulations. The provider-agency must provide long-term storage of clinical records in accordance with Medicaid regulations. Additional record keeping requirements are described in Section 7.



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## **6.9 Emergency Coverage**

Whenever a Therapeutic Integration Specialist is working with a child, there shall be back-up staff (e.g., Clinical Supervisor, Nurse) immediately available to provide consultation and/or direction to staff should a crisis situation develop. This requires a response to a telephone call or page within 15 minutes. An emergency or crisis is characterized by a sudden onset, rapid deterioration of cognition, judgment, behavior or physical health, is time limited in intensity and duration, and poses serious risk of harm to the individual or others. The TCYC provider-agency shall describe its processes for coordinating its emergency plan with a CEDARR Family Center.

## **7.0 QUALIFIED ENTITY**

A certified provider must be able to demonstrate that it complies with core State requirements as to organizational structure and process. These requirements pertain to areas such as incorporation, management of administrative and financial systems, human resource management, information management, quality assurance/performance improvement and others. State requirements in these areas are consistent with the types of expectations or standards which would be set forth and surveyed by health care accrediting bodies and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision.

Applicants for certification are not required to systematically address in detail each of these areas in their certification applications. Rather, these are set forth as fundamental requirements for certified entities. In many areas applicants will be asked to provide assurances that their agency systematically addresses each of the standards identified. In certain areas, more specific description regarding the manner in which the agency meets the standard is required. The Application Guide provides guidance as to how the application should be structured and the areas, which need to be addressed.

In not requiring applicants to explicitly address the elements in Section 7, the State is seeking to simplify the effort needed to develop an application; these certification requirements remain in place. The State reserves the right to review certified entities for compliance with these certification requirements.

### **7.1 Incorporation and Accountable Entity**

The applicant for certification as a TCYC provider-agency must be legally incorporated. The certified entity shall serve as the accountable entity responsible for meeting all of the terms and conditions for providing TCYC. Applicants must clearly present the overall structure by which services, requirements and programmatic goals will be met. The corporate structure of the entity must be clearly delineated.

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### **7.1.1 Partnership or Collaboration**

Satisfactory performance as a certified TCYC provider-agency calls for significant organizational capability. In some cases this capability may be present within a single organization and application for certification will be made based on the strengths of that single organization. In other cases the application may represent the joint effort of several parties, which have the combined capabilities to meet the certification requirements. This could come, for example, through a joint venture, a formal partnership or an integrated series of executed contractual arrangements. Regardless of form, a single legal entity will be certified with overall responsibility for performance.

The certified TCYC provider-agency is to be the single billing agent for all TCYC.

### **7.2 Governance and Mission**

The governance of the entity must be clearly delineated. Composition of the Board of Directors and any conditions for membership must be clear. The overall performance of an organization flows from the philosophy and oversight of the leadership. Leadership and stakeholders “build” the mission, vision and goals; this in turn shapes the business behavior and is reflected in the tone that leadership sets for the operation of the organization. The leadership strives to recruit members who reflect the cultures and ethnic backgrounds of clients, and to provide a mix of competencies that address organizational needs. Specific standards regarding governance and mission are as follows:

- 1) The agency has a clearly stated mission and publicly stated values and goals.
- 2) The agency is operated/overseen by some type of legally or officially established governing body, with a set of governing documents or by laws. This governing body has full authority and responsibility for the operation of the organization.
- 3) The governing body is self-perpetuating and has a recruitment and periodic replacement process for members to assure continuity and accountability.
- 4) The governing body hires, supervises, and collaborates with a chief executive officer or director. Together the executive and governing bodies provide organizational leadership.
- 5) The governing body has final accountability for all programs. Through a collaborative relationship with the executive and the management team, the governing body is responsible for developing the program goals and mission and ensuring compliance with legal and regulatory requirements.

### **7.3 Well Integrated and Organized Management and Operating Structure**

The TCYC provider-agency will be able to function in an efficient and effective manner, assuring consistency and quality in performance and responsiveness to the needs of families. The applicant shall provide clear identification of who is accountable for the performance of TCYC.

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This includes administration, clinical program quality, and management of service delivery and overall financial management.

### **7.3.1 Administration**

Specific standards regarding administration are as follows:

- 1) The Executive, under supervision of the governing body, is responsible for financial management, achieving program outcomes, meeting client needs, and implementing the governing body's strategic goals.
- 3) A current chart of organization, which clearly defines lines of authority within the organization, must be maintained and provided as part of the certification application.
- 3) The management of the organization is involved in the planning process for performance improvement and is involved in planning for priorities and setting goals and objectives for the written Quality Assurance/Performance Improvement plan.
- 4) There is a written corporate compliance plan in place that is adopted by the governing body.

### **7.3.2 Financial Systems**

The organization must have strong fiscal management that makes it possible to provide the highest level of service to clients. Fiscal management is conducted in a way that supports the organization's mission, values, and goals and objectives in accordance with responsible business practices and regulatory requirements. Financial management requires a set of sophisticated financial planning and management capabilities if the organization is to remain viable. The organization must be able to obtain relevant data, process and report on it in meaningful ways, and analyze and draw meaningful conclusions from it. Managers must use financial data to design budgets that match the constraints of the organization's resources, and provide ongoing information to aid the governing body in managing and improving services. Therefore, the financial managers must have the ability to integrate data from all of the client and financial accounting systems (e.g., general ledger, billing and appointment scheduling). Data must also be utilized to make projections for planning and budgeting purposes.

Specific standards regarding financial systems are as follows:

- 1) Financial Management is provided by a Chief Financial Officer, Fiscal Director, or Manager with demonstrated experience and expertise in managing the finances of a human services organization with third party reimbursement. In larger organizations (e.g. with revenues in excess of \$1 million) this might be an MBA with demonstrated finance experience or a CPA; in smaller organizations a comptroller with a degree or experience in accounting might be sufficient. This individual must possess expertise in financial and client/patient accounting, financial planning and management.

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- 2) The organization's financial practices are consistent with the most up to date accounting methods and comply with all regulatory requirements.
  - 3) The organization's financial planning process includes annual budgeting, revenue projections, regular utilization and revenue/expense reports, billing audits, annual financial audits by an independent CPA, and planning to ensure financial solvency.
  - 4) The organization has written policies and procedures that guide the financial management activities (including written policies for and procedures for expenditures, billing, cash control; general ledger, billing system; registration/intake system; payroll system; accounts payable; charge and encounter reporting system and accounting administration).
  - 5) The organization has evidence of internal fiscal control activities, including, but not limited to cash-flow analysis, review of billing and coding activities.
  - 6) The system must track utilization of service units separately for each individual client and aggregate this information by payer, performing provider and diagnosis/problem.
  - 10) The organization has a billing office/function that bills for services rendered and collects fees for service and reimbursement.
  - 8) The organization assesses potential and actual risks, identifies exposures, and responds to these with preventive measures.
  - 9) The organization carries appropriate general liability insurance, and ensures that appropriate professional liability policies are maintained for program personnel.
  - 10) Where the organization contracts with outside entities and/or providers, policies and procedures mandate contract language to detail the entity's or provider's accountability to the Governing Body and its' By-laws.
  - 11) The organization has systems that facilitate timely and accurate billing of fee-for-service, capitated, and case-rated insurance plans, clients and other funding sources. Once bills are forwarded to payers, the system properly manages payments, follow-up billing, collection efforts and write-offs.
  - 12) The organization has a written credit and collections manual with policies and procedures that describes the rules governing client and third-party billing. Specifically, the organization has in place and adheres to policies and procedures ensuring compliance with Medicaid regulations pertaining to coordination of benefits and third party liability. Medicaid by statute and regulation is secondary payer to all other insurance coverage.
  - 13) Clinical, billing and reception/intake staff receives ongoing training and updates regarding new and changed billing and collection rules and regulations.

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## 7.4 Human Resources, Staffing

Human Resource activities within the organization are conducted to ensure that proper staffing for optimum service delivery to clients occurs through hiring, training, and oversight of staff activities. The activities are organized to serve the governing principles of the organization and compliance with these Certification Standards. The organization provides clear information to staff about job requirements and performance expectations, and supports continuing education, both internal and external, that is relevant to the job requirements of the individual. In addition, all staff receive training about major new organizational initiatives and about key issues that may affect the organization overall.

Specific standards regarding Human Resources and Staffing are as follows:

- 1) The organization's personnel practices contribute to the effective performance of staff by hiring sufficient and qualified individuals who are culturally and linguistically competent to perform clearly defined jobs.
- 3) Staff personnel records are kept that contain a checklist tickler system to track appropriate training, credentialing and other activities. A copy of each staff's active license will be kept on file.
- 3) The provider-agency must perform annual written performance appraisals of staff based on input from families and supervisors. These must be available in the personnel files for review by DHS upon request.
- 4) Policies and procedures contain staff requirements for cultural competency that are reflected in the job descriptions.
- 5) Staff is hired that match the requirements set forth in both the appropriate job description and in the policies and procedures.
- 6) Each staff's record contains a job title and description reflecting approved education, experience and other requirements, caseload expectations, supervisory and reporting relationships, and annual continuing education and training requirements. Supervisory job descriptions establish expectations for both contributing to the organization's goal attainment and for communicating the goals and values of the organization. All job descriptions include standards of expected performance.
- 7) The organization provides a clear supervisory structure that includes plainly delineated spans of control and caseloads as appropriate. The roles of team members are defined with a clear scope of practice for each. Supervisors receive specialized training and coaching to develop their capacities to function as managers and experts in their clinical and/or technical fields. The organization holds supervisors accountable for communicating organizational goals, as well as for clinical and technical supervision. This includes:

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- a) Protocols for communication and coordination with all interested parties (e.g., special education, primary care physician, or other specialists).
  - b) Clear procedures for addressing unmet education or licensure requirements will be stated. Credentialing records will be maintained annually to document compliance.
- 8) Credentials of staff established by the management team and approved by the Governing Body are contained in the job descriptions. An individual hired into a position has his or her credentials verified through primary source verification, as appropriate, and records maintained in the staff's record.
  - 9) A record of primary source verification is maintained in the individual staff record. This includes, at a minimum, verification of licensure, review of insurance coverage/ liability claims history, verification of board certification for physicians, verification of education and training required by law, and professional references and performance evaluations about applicant's ability to perform requested duties. The individual staff record for behavioral health practitioners should also contain a signed statement from the practitioner that addresses if any Medicare or Medicaid sanctions have been imposed in the most recent three-year period.
  - 10) Staff has appropriate credentials and meets qualifying standards of the organization. These are updated and checked regularly.
  - 11) The organization provides training and training opportunities for all levels of staff.
  - 12) Staff is required to participate in training activities on an ongoing basis, as specified by the organization and position and job descriptions.

## **7.5 Quality Assurance/Performance Improvement**

The organization is required to have policies and procedures and demonstrable activities for quality review and improvement (e.g. formal Quality Assurance or Performance Improvement plan). The organization ensures that information is collected and used to improve the **overall** quality of service and performance of the program. The Quality Assurance/Performance Improvement (QA/PI) program that the organization develops strives to: improve the systems related to the delivery of service to the clients; include the preferences of clients in the provision of services; and measure the process and outcomes of the program services. The QA/PI program is an ongoing process of planning, monitoring, evaluating, and improving the system in order to improve the outcomes of service provided to clients.

Standards regarding Quality Assurance/Performance Improvement are as follows:

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- 1) The organization has a Quality Assurance/Performance Improvement program that includes a written performance improvement plan with annual review of goals and objectives, data analysis, outcomes management, records review and operational/systems improvement. Written records are maintained for PI program activities.
  - 2) The QA/PI program contains specific timetables for activities and measurable goals and objectives, which consider client concerns and input.
  - 3) Effective data analysis is conducted that includes an assessment of client or organizational needs, identification of service gaps, and integration of that data into organizational decision-making processes.

## **7.6 Information Management, Record Keeping**

The organization must use data to affect the performance, stability, and quality of the services it provides to clients; in its governance; and other systems and processes.

Standards regarding information management, medical and billing record keeping are as follows:

- 1) The organization obtains, manages, and uses information to enhance and improve its performance. Information it maintains is timely, accurate, and easily accessible, whether maintained in electronic or other format. Evidence exists that information gathered and maintained is used in decision-making for the organization.
- 2) The organization maintains a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.
- 3) The organization shall ensure that its information management systems are protected from unauthorized outside access and shall meet all applicable HIPAA regulatory requirements when such standards are promulgated and effective.
- 4) The information management plan specifies standard forms and types of data collected for client intake, admission, assessment, referral, services, and discharge.
- 5) The information management plan has an incident reporting and client grievance-reporting component.
- 6) Information management processes are planned and designed to meet the organization's internal and external reporting and tracking needs, and are appropriate to its size and complexity. Mechanisms exist to share and disseminate information both internally and externally.
  - a) The organization maintains signed releases for sharing of clinical information.

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- b) Where necessary, signed affiliation agreements exist.
  - c) Reports are available on an appropriate schedule (weekly, bi-weekly, monthly, quarterly, etc.) for use by service providers, case managers, supervisors, managers, CEO, and the Governing Body for assessing client and organizational progress.
  - d) Reports to authorities (state, federal, and other funding and regulatory entities) for review are submitted accurately, in the required formats and on a timely basis.
- 7) The organization has written policies and procedures regarding confidentiality, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure.
- a) The organization has policies and procedures in place to safeguard administrative records, clinical records, and electronic records.
  - c) Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.
- 8) Client information is accessible and is maintained in a consistent and timely manner, with enough information to support the consumer's needs or diagnosis, to justify services delivered, and to document a course of treatment and service outcomes.
- a) Every client will have a record that contains: an initial assessment, the detailed therapeutic integration assessment of client assets and needs, client goals as part of the Therapeutic Integration Plan, documentation of care/services provided, documentation of change in client's status, and where necessary, discharge summary.
  - b) All records must include evidence of informed consent, where required.
- 9) The client record documents interventions provided and results from the interventions. All entries into the client records are dated and authenticated, and follow established policies and procedures.
- a) Changes in client's condition or lack of change following service provision are recorded in the client record at the time of service provision and signed by the service provider.
  - b) Achievement of a client objective or milestone toward an objective is noted in the client record. Achievement of an objective or milestone results in a revised assessment.



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- c) Lack of progress in achieving a client objective or milestone toward objective results in a reassessment of the client.
- 10) The client record will be the basis for billing. All service billings must be substantiated in the client record. Additional clarification regarding Medicaid and DHS requirements is included in Appendix.

## **7.7 Health and Safety, Risk Management**

The organization supports an environment that promotes optimal safety and reduces un-necessary risk for clients, family members and staff. The center-based nature of TCYC calls for specific policies and procedures to assure that services are provided in a safe and effective manner for both the child and the staff.

Standards regarding Health, Safety, and Risk Management are as follows:

- 1) The organization's policies and procedures designate managers who monitor implementation of Health and Safety policies and report to the Quality Assurance Performance Improvement program committee and the Governing Body.
- 2) The organization will have protocols for identification and monitoring of safety risks, family crises, medical emergencies and difficult situations.
- 3) Health and safety policies and procedures are clearly communicated to agency staff, visitors, and clients.
- 4) Programs will have an effective incident review process.
- 5) OSHA guidelines
- 6) All Federal and State mandates

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## **APPENDIX 1: DEFINITION OF MEDICAL NECESSITY**

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As defined and applied to all State Medicaid programs (See: RI DHS Medical Assistance Program, 300-40-3, September 1997), Medical Necessity refers to medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition. It includes services necessary to prevent a detrimental change in either medical or mental health status. Services must be provided in the most cost effective, efficient and appropriate manner. Services are not to be provided solely for the convenience of the beneficiary or service provider.

The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. The Medical Assistance Program is the final arbiter of determination of medical necessity (See RI DHS Medical Assistance Program, 300-40-4, September, 1997).

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## **APPENDIX 2: CEDARR FAMILY CENTER REVIEW and AUTHORIZATION PROCESS FOR TCYC**

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Families may seek TCYC through referral by a CEDARR Family Center and authorization by DHS. Services provided by a CEDARR Family Center are intended to benefit families by helping them obtain information, navigating the system of services and supports and identifying the appropriate services for their child. The CEDARR Family Center helps by arranging specialty clinical evaluations if required, conducting an Initial Family Assessment, developing a Family Care Plan, and providing coordination of care, when requested by the family.

When the CEDARR Family Center makes recommendations for services and supports, parents are given information about various professionals, resources, and different agencies providing those services. The following process takes place:

- 1) If TCYC is recommended, families are given several TCYC Direct Service Providers to choose from. The family will choose one or more of these providers. The CEDARR Family Center will work to connect the family with the TCYC provider(s) of their choice. TCYC providers will contact the family to set up an appointment at a time and location convenient for the family. The TCYC provider will schedule the assessment/observations necessary for the development of the Therapeutic Integration Plan.
- 2) The TCYC Direct Service Provider then submits a Therapeutic Integration Plan to the CEDARR Family Center for review and the CEDARR Family Center reviews it. As appropriate, the CEDARR Family Center forwards it to DHS for authorization.
- 3) The specifics necessary for authorization are as follows:
  - a) TCYC provider-agencies must develop and submit written Therapeutic Integration Plans to the CEDARR Family Center no later than four weeks after receiving the written referral from the CEDARR Family Center. Retroactive requests and/or unauthorized periods of providing services are not allowed.
  - b) The Therapeutic Integration Plan must include clearly defined interventions and objectives with measurable outcomes. The names of the individual providing clinical supervision and of the Therapeutic Integration Specialist(s) must be identified, along with their hours.
  - d) Each Therapeutic Integration Plan receives a thorough review. Therapeutic Integration Plans are reviewed within thirty (30) days of their receipt at the CEDARR Family Center.
  - d) The review process frequently involves written and verbal communication between provider-agencies and the CEDARR Family Center in order to facilitate a thorough understanding of the proposed services. As a result, recommendations to modify a

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- Therapeutic Integration Plan may be made in terms of goals or intensity of services. Changes in intensity of services require parental consent.
- e) Based on review, actions are taken by the CEDARR Family Center for authorization by DHS. Written notification is sent directly to provider-agencies by EDS.
  - f) Provider-agency cooperation is sought to resolve questions prior to issuing a denial of authorization. The provider-agency must then review proposed changes with a child's parents/guardians and obtain their consent. Once a revised plan has been obtained, services may then be authorized with written notification to the provider-agency and family.
  - g) If a Therapeutic Integration Plan is unsatisfactory, the provider-agency has nine (9) calendar days to respond to the reviewer's questions or concerns. Written responses are required of provider-agencies. Untimely or unsatisfactory responses may result in changes to a Therapeutic Integration Plan including reductions in intensity or duration, or denial of a Plan.
  - h) Families have the right to appeal any denial of TCYC or modification of intensity of services, to the provider agency, the CEDARR Family Center or DHS.
  - i) If there are substantial changes in a child's level of functioning (e.g., inpatient hospitalization or regression) that could require service changes during an approved period of care, it is the responsibility of the provider-agency to inform the CEDARR Family Center and receive approval to amend the Therapeutic Integration Plan. These requests are then subject to the same review process as for initial requests.
  - j) Provider-agencies have the responsibility to submit a request for reauthorization of care thirty (30) days prior to the expiration of an existing Therapeutic Integration Plan.
- 4) The CEDARR Family Center is responsible for providing the following functions: reviewing the Therapeutic Integration Plan and forwarding it to DHS for prior authorization, oversight, and collaboration with the TCYC provider-agency.
  - 5) The TCYC Direct Service Provider is responsible to the CEDARR Family Center for all utilization and authorization of care. In order to render TCYC as a direct service, the provider-agency must be certified as a CEDARR Direct Service Provider.

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## APPENDIX 3: LICENSURE AND PRACTICE STANDARD

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### 1. Core Requirements for TCYC Certification

#### 1.1 Licensure

All child and/or youth care facilities applying for DHS Certification to provide Therapeutic Child and Youth Care shall hold a current license as a Child Day Center or School Age Day Care Provider from the Department of Children, Youth and Families. Relevant law is Chapter 72.1 of the General Laws of Rhode Island.

These Certification Standards require that individuals engaged in providing the Therapeutic Integration Assessment Plan Development and Clinical Supervision as part of TCYC hold a currently valid license from the Rhode Island Department of Health (DOH) or current certification as a Special Educator from the Department of Education (DOE). DOH requires that professionals be licensed for their respective specialties (i.e., nursing, psychology, social work, marriage and family therapy, mental health counseling). For social workers, an LICSW (Licensed Clinical Social Worker) is required by DHS for engaging in the practice of Clinical Supervision and TCYC. For nurses, a registered nurse with a Master's degree is required to provide clinical supervision.

DOH stipulates that licensure is required for health care professionals if:

You represent yourself in name, title, or abbreviation to the public as a psychologist, clinical social worker, or registered nurse

You engage in providing diagnosis, assessment, treatment planning, and treatment to the public.

Relevant DOH policies are:

- Clinical Social Worker: R5-39.1 CSW/ICSW
- Psychologist: RS-44-PSY
- Nurse: R5-34-NUR/ED
- Mental Health Counselors: RS-63.2-MHC/MFT
- Marriage and Family Therapists: RS-63.2-MHC/MFT

Relevant DOE policies are:

- Special Education

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## 1.2 Competency

Licensure relates to broad areas of clinical practice and by itself does not ensure that providers have the specific and current competencies to work effectively children with the special needs addressed in TCYC. In addition to licensure, DHS requires that individuals engaged in providing Clinical Supervision in TCYC demonstrate competency to work with specific target populations. Specifically, evidence of the following is required:

- 1.2.1. Training: 2 years of supervision post degree while working with related target population(s); and
- 1.2.2 Continuing Education Licensed clinicians must conform to the requirements of their respective Boards for maintaining continuing education credits. Provider-agencies are responsible for oversight and management of this requirement.

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**APPENDIX 4:            DESCRIPTIONS OF CONDITIONS ASSOCIATED WITH  
TARGET POPULATION:**

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Diagnostic conditions for which TCYC may be appropriate can include, but are not limited to, those noted below. This is provided as a point of reference only. TCYC may be effective for children with diagnoses other than those noted here. Appropriateness determination should be based on multiple factors and not diagnosis alone.

- Autistic Spectrum Disorders and Pervasive Developmental Disorders - refers to a wide continuum of associated cognitive and neuro-behavioral disorders characterized by, but not limited to, three core defining features: impairments in reciprocal social interactions, impairments in verbal and nonverbal communication, and restricted and repetitive patterns of behaviors or interests. There is marked variability in the severity and complexity of symptomatology across individuals as well as intellectual functioning that can range from profound mental retardation to the superior level of cognitive ability.

Autistic Disorder  
Pervasive Developmental Disorder Not otherwise Specified  
Asperger's Disorder  
Rett's Syndrome (Rett's Disorder)  
Childhood Disintegrative Disorder

- Developmental Disability means a severe, chronic disability, other than mental illness, which: a) is attributable to a cognitive or physical impairment or combination of cognitive and physical impairments, b) is manifested before the person attains age 22, c) is likely to continue indefinitely, d) results in substantial functional limitations in 3 or more of the following areas of major life activities (i) self care, (ii) receptive and expressive language, (iii) learning, (iv) mobility (v) self direction, (vi) capacity for independent living, (vii) economic self sufficiency and e) reflects the person's need for a combination and sequence of special, inter-disciplinary, generic care or other services which are life-long or of extended duration.
- Mental Retardation - refers to significantly sub-average general intellectual functioning accompanied by significant limitations in adaptive functioning (e.g., communication, self-care, home living, social or interpersonal skills, use of community resources, functional academic skills, work, leisure, health and safety). The severity of mental retardation and level of adaptive functioning varies given the degree of a child's impairment:

Mild Mental Retardation	IQ level 50 - 70
Moderate Mental Retardation	IQ level 35 - 50
Severe Mental Retardation	IQ level 20 - 35
Profound Mental Retardation	IQ level below 20

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Psychiatric and Behavioral Disorders - refer to children and adolescents with a range of conditions, which result in impaired or compromised levels of functioning across various domains. Examples are:

- Attention Deficit Hyperactivity Disorder
- Conduct Disorder
- Intermittent Explosive Disorder
- Opposition Defiant Disorder
- Tourette's Disorder
- Mood Disorders (e.g., Depression and Bipolar Disorders)
- Anxiety Disorders (e.g., Panic Disorder, Post Traumatic Stress Disorder, Generalized Anxiety Disorder, Obsessive - Compulsive Disorder, and Social Phobia)

General Medical and Physical Conditions - refers to a wide range of conditions with complex genetic, metabolic and/or neurological factors that significantly affect a child's functioning. Some of these conditions are:

- Angelman's Syndrome
- Cerebral Palsy
- Duchenne's Muscular Dystrophy
- Klinefelters Syndrome
- Landau-Kleffner Syndrome
- Prader Willi Syndrome
- Tuberous Sclerosis
- Seizure Disorder



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**APPENDIX 5: PROVIDER-AGENCY RESPONSIBILITY FOR MONITORING  
MEDICAID ELIGIBILITY**

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A recipient's eligibility to receive Medicaid can change at any time. It is the responsibility of the provider to verify eligibility. This can be accomplished by contacting the Recipient Eligibility Verification System (REVS) at 784-8100.

Loss of Medicaid coverage results in nonpayment of claims.

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## **APPENDIX 6: THERAPEUTIC CHILD AND YOUTH CARE SAMPLE ASSESSMENT TOOL PROTOCOL**

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### **Child/Youth Care Setting Information**

1. What are the physical aspects of the environment which could affect the center's ability to accommodate children with special health care needs (e.g. ramps, toileting facilities, safety, adapted equipment and facilities.)
2. What are the needs of other children or youth currently in care which could affect the center's ability to accommodate children with special health care needs (e.g. children with behavioral challenges, safety precautions, diversion activities).
3. What are the staff and parents' concerns regarding children with special health care needs in the center (e.g. concern that the child's needs will require too much attention and distract from the needs of other children). How can these concerns be addressed?
4. What are the program considerations (i.e. curriculum, schedule and daily activities) which could affect the center's ability to accommodate children with special health care needs?

### **Child Specific Information**

Sample questions that follow are critical areas to be considered by the licensed health care professional or certified special educator in conducting the Therapeutic Integration Assessment. They are meant to be examples of prompts which can be used to lead to a more detailed discussion of the child's functioning in each area.

### **Health/Medical/Nutrition**

Factors to be considered: medical history, medications, allergies, vision/hearing, and immunization status.

Sample Questions:

- Does medication need to be administered?
- Will the foods the child eats require special attention?
- Are there any warning signs the child-care provider will need to know?
- Does the child require a skilled nurse for assessment, medical procedure or monitoring?

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## **Personal Care**

Factors to be considered: diapering, special equipment for personal care tasks, skin care needs, level of independence, dressing, using the bathroom, personal grooming.

Sample Questions:

- Will someone need to toilet or diaper the child?
- Will the child-care setting need any physical modifications (e.g. change table, booster steps in bathroom)?
- How much help will the child require when getting ready to go outside?
- Will the child require assistance in eating?

## **Social Interactions**

Factors to be considered: reaction to new people, relating to other children, taking turns, sharing, energy level, passivity, irritability.

Sample Questions:

- Will the child need help playing with others?
- Does the child need help in turn taking or sharing?
- Is monitoring of the child's behavior with others needed?
- Will help be needed to encourage the child's participation in group activities?

## **Play/Activities/Interests**

Factors to be considered: use of materials, interaction in games, focus on an activity, attention span, creative playing, favorite activities.

Sample Questions:

- Will someone need to help the child participate in the routines of child/youth care?
- Will some of the child-care setting's activities need to be changed so the child can participate?
- Will some toys or materials need to be modified so the child can use them?

## **Communicating With and Understanding Others**

Factors to be considered: use of gestures, signs, sounds, words, assistive technology, vocabulary, reading and writing, speaking intelligibly, following directions, listening skills, attention span when communicating.

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Sample Questions:

- Is an alternative communication system (such as signing or picture symbols) used by the child?
- Does the child's attempts to communicate need to be "translated"?
- Will someone need to help the child work through his/her frustrations if confronted with a challenge?

**Motor Skills**

Factors to be considered: moving around indoors and outdoors; using outdoor/gym equipment; use of special equipment, e.g. standing frame or wheelchair; need for switch toys/computers/splints

Sample Questions:

- Does the child need to be positioned for any of the center's activities?
- Does the child require any hand-over-hand assistance for specific activity? (e.g. painting, eating with a spoon).
- Are any modifications needed in the center to accommodate the child or child's equipment?

**Behavior**

Factors to be considered: impulsive actions, understanding limits, danger to self/others, responses to new surroundings.

Sample Questions:

- Is additional monitoring of the child inside and/or outside the child-care setting needed to ensure safety?
- Will a child-care provider need to monitor the child to help ensure the safety of others?
- Are specific procedures needed to work on the child's behavior?
- Will the center need to be modified to ensure a safe environment for the child?

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## **APPENDIX 7 DEVELOPMENT OF THE THERAPEUTIC INTREGRATION PLAN**

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The development of the therapeutic plan is a shared responsibility among the parent, licensed clinician/health care professional, Director/Head Teacher of the provider agency and the child or youth when appropriate. In developing the plan, consideration must be given to the child's/youth's strengths and needs in the following areas:

- health/medical/nutrition
- personal care
- social interaction
- play, activities and interests
- communicating with and understanding others
- understanding concepts and problem solving
- motor skills
- behavior
- safety

Strengths describe what the child/youth can do and needs describe what the child should be able to do for successful participation in the child/youth care center. These strengths and needs, derived from the information gathered during the therapeutic assessment process, serve as the basis for the development of the plan.

Goals should be set which specify the progress the child or youth could reasonably be expected to accomplish in each area in a six-month period. Objectives or interim steps should be identified which include procedures, accommodations, modifications, supports, etc., needed to achieve progress toward the goals and the criteria by which progress will be measured.

**SAMPLE THERAPEUTIC INTEGRATION PLAN**  
 (The following is suggestive only)

**ABOUT CHILD**

**ABOUT PROVIDER**

Child's Name: \_\_\_\_\_  
 Center: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_  
 Child's Date of Birth: \_\_\_\_\_  
 Child's chronological Age \_\_\_\_\_  
 Identification Of Assigned Staff:  
 Clinical Supervisor: \_\_\_\_\_  
 \_\_\_\_\_  
 Therapeutic Integration Specialist(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Nurse (If applicable): \_\_\_\_\_  
 \_\_\_\_\_

Child/Youth Care Provider: \_\_\_\_\_  
 \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Director of Agency: \_\_\_\_\_  
 DCYF Agency License Number: \_\_\_\_\_  
 \_\_\_\_\_

**Health/Medical/Nutrition Goal(s):**

Strengths	Needs	Objectives	Procedures	Criteria

**Personal Care Goal(s):**

Strengths	Needs	Objectives	Procedures	Criteria

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**Social Interactions Goal(s):**

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<b>Strengths</b>	<b>Needs</b>	<b>Objectives</b>	<b>Procedures</b>	<b>Criteria</b>

---

**Play, Activities and Interests Goal(s):**

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<b>Strengths</b>	<b>Needs</b>	<b>Objectives</b>	<b>Procedures</b>	<b>Criteria</b>

---

**Understanding Concepts and Problem Solving Goal(s):**

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<b>Strengths</b>	<b>Needs</b>	<b>Objectives</b>	<b>Procedures</b>	<b>Criteria</b>

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**Motor Skills Goal(s):**

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<b>Strengths</b>	<b>Needs</b>	<b>Objectives</b>	<b>Procedures</b>	<b>Criteria</b>

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**Behavior and Safety Goal(s):**

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<b>Strengths</b>	<b>Needs</b>	<b>Objectives</b>	<b>Procedures</b>	<b>Criteria</b>

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## **APPENDIX 8: PARENT PARTICIPATION IN TCYC**

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Parent participation in the development of a child's Therapeutic Integration Plan is required. Parent or guardian approval of all Therapeutic Integration Plans - initial, revised, and renewal requests for continuing TCYC - is also required. Therapeutic Integration Plans must contain a parent or guardian's signature. The parent or guardian shall sign the plan before it is sent to the CEDARR Family Center for review. The Therapeutic Integration Plan must include a statement regarding the expectation for regular communication with parents.

For families involved with DCYF and having a case plan, CEDARR Family Centers must coordinate all aspects of a child's TCYC plan to insure compliance with DCYF mandates or expectations for a family under its care.



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## **APPENDIX 9: PROVIDER-AGENCY RESPONSIBILITIES FOR DISCONTINUATION OF TCYC**

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DHS recognizes that there may be critical situations whereby continued TCYC becomes compromised or inappropriate, necessitating suspension or discontinuation of care. These can include, but are not limited to, risks to the safety and welfare of the child, the Therapeutic Integration Specialist, or other children and child care staff. As such, the TCYC provider-agency has responsibility to exercise prudent judgment and prevent abandonment of care when responding to crisis situations. The following guidelines are to be followed:

- 1) Parental participation in the development and application of a child's Therapeutic Integration Plan is an ongoing process whereby critical situations or circumstances are identified and addressed.
- 2) Written documentation regarding critical concerns is required and will serve to identify risks and actions to be taken to reduce or eliminate further recurrence of problem situations. A copy is to be maintained as part of the child's Therapeutic Integration Plan. Possible responses may involve modifications to the authorized plan, including referrals for emergency psychiatric evaluation, hospitalization, individual or family therapies, DCYF services, or other actions (e.g., reassessing intensity, methods etc.) which are to be coordinated with the CEDARR Family Center
- 3) When multiple efforts to resolve difficulties have failed and are documented, the provider-agency can initiate discontinuing TCYC, namely:
  - a) The child's family or guardian as well as the CEDARR Family Center must receive written notification 30 days prior to discontinuing TCYC. Reasons for discontinuing treatment must be stated. Alternative resources, and/or referrals if appropriate, must be given and forwarded to the CEDARR Family Center.
- 4) CEDARR Family Center must receive immediate written notification if a situation develops which necessitates the immediate termination or suspension of TCYC.
- 5) A parent or guardian has the right to terminate TCYC at any time during an authorized course of care. The provider-agency must have written policies to facilitate an orderly transition of care, and/or follow-up or referral services, and communicate with the CEDARR Family Center.

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## APPENDIX 10: CEDARR FAMILY CENTERS

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**1. About Families**

**CEDARR Family Center  
203 Concord St. Suite 335  
Pawtucket, RI 02860**

**401-365-6855**

**2. Families First CEDARR**

**Hasbro Children's Hospital  
593 Eddy Street, Room 120  
Providence, RI 02903**

**401-444-7703**

**3. Family Solutions CEDARR**

**134 Thurbers Avenue, Suite 102  
Providence, RI 02905**

**401-461-3251**

**4. Easter Seals CEDARR Family Center**

**5 Woodruff Ave.  
Narragansett, RI 02882**

**401-284-1000**

**Note: Additional CEDARR Family Centers may be certified periodically.**

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## APPENDIX 11: APPEAL RIGHTS - RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

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### APPEAL RIGHTS - READ CAREFULLY

You have a right to discuss this action further with me or my supervisor, or to request an adjustment conference with the appropriate DHS Supervisor. **If you have questions regarding this notice, call the Agency representative at the telephone number listed on the first page of the notice.**

You have the right to request and receive a hearing if you disagree with the decision made regarding the level or length of services, in the approved Treatment Plan. You must request a hearing in writing within thirty (30) days of this notice.

If you request a hearing regarding your medical services within ten (10) days of this notice, you will continue to receive the current amount of Medical Assistance Services until a hearing decision is made.

The form to request a hearing is enclosed. If you request a hearing you may represent yourself or authorize another person, such as a relative or legal counsel to represent you. Free legal help may be available by calling Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

**EXCEPTION:** If this action implements a hearing decision, you may not have the right to another hearing on this action. See the hearing decision letter for your right for judicial review in accordance with Rhode Island law (42-35-1 et seq.).

### TO REQUEST A HEARING

All requests must be in writing. To request a hearing, complete Section I., the 'Statement of Complaint' on the REQUEST FOR A HEARING form or else submit your complaint in writing. Briefly describe the Agency action you wish to appeal. You can fill out the form yourself, or with the help of the Agency representative if you need help in completing the form. The form is signed by the person to whom the notice is addressed or her/his representative.

Mail or bring the hearing request form to the Center for Child and Family Health, Department of Human Services Forand Building, 600 New London Avenue, Cranston, RI 02920. In order to receive a hearing, you must do so within the time periods specified on this page. You will be notified of the time and place of the hearing. At the same time, you will also receive a statement of the Agency's position, an explanation of the policy on which the decision was based, and additional information about the hearing process.

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## INFORMATION ABOUT HEARINGS FOR APPLICANTS AND RECIPIENTS OF FINANCIAL ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE AND SOCIAL SERVICES

The Department of Human Services (DHS) has a responsibility to provide financial assistance, food stamps, medical assistance, and social services to individuals and families for whom eligibility is determined under the provisions of the Social Security Act, the Rhode Island Public Assistance Act, the Food Stamp Act, the Rhode Island Medical Assistance Act and Title XCX Social Services.

The hearing process is intended to insure and protect your right to assistance and your right to have staff decisions reviewed when you are dissatisfied. You have asked for a hearing because of an agency decision with which you disagree. The following information is sent to help you prepare for your hearing and to inform you about what you may expect and what will be expected of you when it is held.

### **1. WHAT IS A HEARING?**

*A hearing is an opportunity provided by the Department of Human Services to applicants or recipients who are dissatisfied with a decision of the agency, or a delay in such a decision for a review before an impartial appeals officer to insure correct application of the law and agency administrative policies and standards.*

### **2. WHO CONDUCTS A HEARING?**

A hearing is conducted by an impartial appeals officer appointed by the Director of the Department of Human Services to review the issue(s) and give a binding decision in the name of the Department of Human Services,

### **3. WHO MAY ATTEND A HEARING?**

A hearing is attended only by persons who are directly concerned with the issue(s) involved. You may be represented by legal counsel if you chose and another witness or a relative or friend who can speak on your behalf. The Agency is usually represented by the staff member involved in the decision and/or that worker's supervisor. Legal services are available to persons wishing to be represented by legal counsel through Rhode Island Legal Services (274-2652) or (1-800-662-0534).

If an individual chooses to have legal representation, e.g. be represented by an attorney, paralegal, or legal assistant, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the agency case record. **It** is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

### **4. WHERE IS THE HEARING HELD?**

The hearing may be held at a regional or district office or in an individual's home when circumstances require.

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## **5. HOW CAN YOU LEARN ABOUT THE DEPARTMENT'S RULES AND REGULATIONS?**

Section III of the attached form (DHS-121) shows the policy manual references, which are at issue in your hearing. You may review the Department's regulations at any local welfare office during regular business hours.

You may also review the Department's hearing decisions rendered on or after April 1987. They are available only at the DHS Central Administration Building, 600 New London Avenue, Cranston Rhode Island, between the hours of 9:00 a.m. and 11:00 a.m. and between the hours of 1 :00 p.m. and 3:00 p.m. Monday through Friday.

## **6. WHAT ARE YOUR RIGHTS RELATIVE TO THE HEARING?**

You have a right to examine all documents and records to be used at the hearing at a reasonable time before the date of the hearing, as well as during the hearing.

You may present your case in any way you wish without undue interference, by explaining the situation yourself or by having a friend, relative, or legal counsel speak for you, and you may bring witnesses and submit evidence as discussed above to support your case. You will have an opportunity to question or refute any testimony or evidence and to confront and cross-examine adverse witnesses.

## **7. HOW IS A HEARING CONDUCTED?**

A hearing differs from a formal court procedure because you are not on trial and the appeals officer is not a judge in the courtroom sense. However, any person who testifies will be sworn in by the appeals officer.

After you have presented your case, the staff member will explain the provisions in law or agency policy under which s/he acted. When both sides have been heard, there will be open discussion under the leadership and guidance of the appeals officer. The entire hearing is recorded on tape.

## **8. HOW WILL THE HEARING DECISION BE MADE?**

The tape recording of the testimony of the persons who participated in the hearing, together with all papers and documents introduced at the hearing, will be the basis for the decision.

The appeals process is generally completed within 30 days of the receipt of your request, but will never exceed sixty (60) days for food stamps and ninety (90) days for all other programs unless you request a delay, in writing, to prepare your case.

The appeals officer will inform you of her/his findings, in writing, following the hearing. If you are still dissatisfied, you have a right to judicial review of your case. The agency staff member wants to be as helpful as possible in assisting you to prepare for the hearing. If you have any questions about what you may expect, or what may be expected of you, be assured that you may call your eligibility technician or worker.

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## APPENDIX 12: DOCUMENTATION GUIDELINES FOR TCYC

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### I. Documentation Requirements

- A. Providers are required to keep all records necessary to fully disclose the nature and extent of the services provided to children receiving TCYC. Providers must furnish to DHS, its agents and/or the Medicaid Fraud Control Unit of the Attorney General's Office such records and any other information regarding payments for claimed or services rendered that may be requested. These guidelines are applicable to all children receiving TCYC services authorized by DHS.

#### Documentation - The Basics

The following are the basic principles of documentation. They apply to all types of services (i.e., Clinical Supervision, Therapeutic Integration).

1. The service/client record should be complete and legible.
  2. The documentation of each client encounter should include or provide reference to:
    - a) Written intervention or progress notes including date, units of therapeutic integration services delineated and that a corresponding number of hours were billed to Medicaid, legible identity/credentials of care provider and the client's progress toward goals, response to and changes in interventions.
    - b) Any revision of the Therapeutic Intervention Plan should be documented by the Clinical Supervisor.
    - c) Identification of the care provider for the child encounter
- B. Each provider is responsible for devising a system that documents those services which have been provided. This back-up information is usually contained in the client record, daily log, or both and must be sufficiently detailed to show that a client received a specific number of hours of services on a certain day.
- C. All Therapeutic Child and Youth Care must be provided in accordance with the Therapeutic Integration Plan.
- D. Methods of Documentation:

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1. A discharge summary must be entered into the client record within 2 weeks after discharge by the Clinical Supervisor. The Discharge Summary must include:
    - a) General observations about the client's condition initially, during interventions and at discharge.
    - b) Whether the discharge was planned or unplanned and, if unplanned, the circumstances necessitating the discharge.
    - c) Assessment of progress toward the Therapeutic Integration Plan objectives.
    - d) Documentation of the summary being sent to the CEDARR Family with recommendations for referral to other appropriate program or agency.

## **II. Monitoring and Quality Assurance**

Site visits will be conducted by DHS staff to monitor appropriate use of Medicaid services and compliance with the procedures outlined in this document. During these visits, staff will review the following:

- Client records and Therapeutic Integration Plans
- Staff orientation programs and attendance logs
- Agency policy and procedures related to TCYC service provision
- Claims information/documentation
- Staff time sheets
- Complaint log

Providers will be notified of DHS site visits in advance if possible. Unannounced site visits may also be conducted at the discretion of the Department. DHS staff may contact or visit families as part of the oversight and monitoring activities.

In the event of adverse findings of a minor nature, repayment to DHS will be required. In situations where, in the opinion of the Department, significant irregularities in billing or utilization are revealed, providers may be required to do a complete self-audit in addition to making repayments. In either case, technical assistance in developing and implementing a plan of corrective action, where appropriate and applicable, will be offered to the provider.

In addition to monitoring conducted by DHS, providers are subject to periodic fiscal and program audits by the Center for Medicare and Medicaid Studies (CMS).

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### III. Client Record Guidelines

All TCYC must be provided in accordance with the Therapeutic Integration Plan that documents the medical necessity of the services. Plans for clients for whom providers are billing Medicaid must conform to the following guidelines:

1. Each client shall have a current written, individualized Therapeutic Integration Plan that is based on assessments of the client's strengths and needs which precluded participation in child or youth care without the support provided by the Therapeutic Integration Plan.
2. Responsibility for the overall development and implementation of the Therapeutic Integration Plan must be assigned to an appropriately qualified health care professional.
3. The Therapeutic Integration Plan must be thoroughly reviewed at major decision points in each client's course of intervention including:
  - (a) The time of admission and discharge
  - (b) A major change in the client's condition
  - (c) At least every six months of treatment.
5. The Therapeutic Integration Plan must contain specific goals toward which the client must progress, achieve and/or maintain. These goals must be based on periodic assessments of the client and as appropriate, the client's family.

### IV. Supplemental Guidelines:

1. Medicaid is, by definition, a medical program, which pays for medical services. A Therapeutic Integration Plan must be signed by the Clinical Supervisor.
2. The diagnosis must clearly be evident in the Therapeutic Integration Plan and the diagnosis must be considered as the overall plan is developed
3. The reasons for and types of intervention to facilitate participation and inclusion in the child or youth care setting should be evident in the plan.
4. Progress notes should reflect a judgment being made by the Clinical Supervisor regarding the results of the intervention rendered, i.e., an assessment of why the interventions are/are not working. The notes should also show that the writer is aware of why things were done rather than merely what was done.



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## APPENDIX 13 - SERVICE MONITORING AND REPORTING REQUIREMENTS

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### *Draft Quarterly Report Protocols*

#### **Report 1: Compliance with required child to staff ratio**

Requirements for this report will be delineated at a later date.

#### **Report 2: Timeliness of intake appointments– *Draft report format***

- Step 1. Identify all new clients who had an initial intake appointment during the reporting period (e.g., April 1, 2003 - June, 2003.)
- Step 2. Log the client's name, client MID, date the referral, and date of the intake appointment in columns 1 - 4 on the Report 2 Worksheet.
- Step 3. Calculate the number of calendar days between the date of the referral (column 3) and the date of the initial intake appointment (column 4) and enter that number into column 5, days from referral to intake.
- Step 4. If the number of calendar days between treatment referral and intake appointment (column 5) is  $\leq 14$  days, enter "yes" into column 7, meets intake appointment standard. If the number of days is greater than 14, enter "no" into column 7.
- Step 5. Count the number of "yes's" in column 7.
- Step 6. Divide the total number of intake appointments taking place within 14 calendar days of written treatment referral by the number of intake appointments taking place within the reporting period to determine if the agency meets the performance standard. (number of plans meeting standard - "yes's from column 7/total number of intake appointments taking place in the reporting period)
- Step 7. Report the percentage from Step 6 on the Quarterly Report sheet, in the row labeled Report 2, Timeliness of intake appointments.

#### **Report 3: Timeliness of new Therapeutic Integration Plan submissions– *Draft report format***

- Step 1. Identify all Therapeutic Integration plans that were submitted for authorization during the reporting period. (e.g., April 1, 2003 – June 30, 2003.)
- Step 2. Log the client's name, client MID, the date of the intake appointment, and the date the Therapeutic Integration Plan was submitted to the CEDARR Family Center for authorization in columns 1 - 4 on the Report 3 Worksheet.

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- Step 3. Calculate the number of calendar days between the date of intake appointment (column 3) and the date the Therapeutic Integration Plan was submitted to the CEDARR Family Center for authorization (column 4), and enter that number in column 5.
- Step 4. If the number of calendar days between the intake appointment and the date the Therapeutic Integration Plan was submitted for authorization (column 5) is  $\leq 28$  days, enter “yes” in column 7, meets Therapeutic Integration Plan submission standard. If the number of days is greater than **28**, enter “no” in column 7.
- Step 5. Count the number of “yes’s in column 7.
- Step 6. Divide the number of Therapeutic Integration plans submitted for authorization within **28** calendar days of intake appointment by the total number of treatment plans that were submitted for authorization during the reporting period to determine if the provider agency meets the performance standard (number of plans meeting standard - “yes’s from column 7/total number of Therapeutic Integration plans submitted for authorization in the reporting period)
- Step 7. Report the percentage from Step 6 on the Quarterly Report sheet, in the row labeled Report 3, Timeliness of new Treatment Plan submission.

**Report 4: Timeliness of service initiation for new clients – *Draft report format***

- Step 1. Identify all new clients who had services initiated during the reporting period (e.g., April 1, 2003 and June 30, 2003)
- Step 2. Log the client’s name, client MID, the date of receipt of Therapeutic Integration Plan authorization, and date of the initiation of services (first date for which direct services are billed) in columns 1 - 4 on the Report 4 Worksheet.
- Step 3. Calculate the number of calendar days between the date the notification of approval of the Therapeutic Integration Plan was received from the CEDARR Family Center (column 3) and the date of service initiation (column 4), and enter that number into column 5, timeliness of initiation of services.
- Step 4. If the number of calendar days between notification from the CEDARR Family Center and the initiation of service (column 5) is  $\leq 21$  days, then enter “yes” in column 7, timeliness of initiation of services. If the number of days is greater than **21**, enter “no” in column 7.
- Step 5. Count the number of “yes’s in column 7.
- Step 6. Divide the total number of clients for whom services were initiated within **21** days of notification of Therapeutic Integration Plan approval from the CEDARR Family Center

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by the number of clients for whom services were initiated during the reporting period to determine if the provider agency meets the performance standard. (number of plans meeting standard - "yes's" from column 7/total number of Therapeutic Integration plans for which services were initiated in the reporting period)

Step 7. Report the percentage from Step 6, on the Quarterly Report sheet, in the row labeled Report 4, Timeliness of service initiation for new clients.

**Report 5: Timeliness of renewal Treatment Plan submissions**

Requirements for this report will be delineated at a later date

Please submit reports on a quarterly basis to:

**Sharon Kernan,  
Assistant Administrator  
Center for Child and Family Health  
Rhode Island Department of Human Services  
600 New London Avenue  
Cranston, Rhode Island 02920**

## Draft TCYC Quarterly Report Format

<b>Report No.</b>		<b>Results (Percent of standard met)</b>
1	Compliance with Required Child to Staff ratio (Format to be determined)	
2	Timeliness of intake appointments	
3	Timeliness of new Therapeutic Integration Plan submissions	
4	Timeliness of service initiation for new clients	
5	Timeliness of renewal treatment plans submission (Format to be determined)	

## Report 2

Timeliness of intake appointments

1	2	3	4	5	6	7
Client Name	Client MID	Date of Referral	Date of Intake Appointment	Days from Referral to Intake	Standard of Timeliness from Referral to Intake	Meets Timeliness of Intake Standard

# Report 3

## Timeliness of Therapeutic Integration Plan submissions

1	2	3	4	5	6	7
Client Name	Client MID	Date of Intake Appointment	Date of Treatment Plan Submission	Days from Intake to Treatment Plan Submission	Standard of Timeliness from Intake to Submission	Meets Timeliness of Submission Standard

**Report 4**

**Timeliness of service initiation for new clients**

1	2	3	4	5	6	7
Client Name	Client MID	Date of Receipt of Treatment Plan Authorization	Date of Initiation of Direct Services	Days from Authorization to Initiation of Services	Standard of Timeliness of Authorization to Initiation of Services	Meets Timeliness of Initiation of Services Standard

**Suggested New Referral Log**

						Report 2	
0	1	2	3	4	5	6	7
Row No.	Client Name	Client MID	Date of Referral	Date of Intake Appointment	Days from Referral to Intake	Standard: Timeliness of intake appointment (days)	Meets Timeliness of Intake Standard
1						14	
2						14	
3						14	
4						14	
5						14	
6						14	
7						14	
8						14	
9						14	
10						14	
11						14	
12						14	
13						14	
14						14	
15						14	
16						14	
17						14	
18						14	
19						14	
20						14	



**Suggested New Referral Log**

					Report 3	
0	1	2	3	4	6	7
Row No.	Client Name	Client MID	Date of Treatment Plan Submission	Date from Intake yo Treatment Plan Submission	Standard: Timeliness of new TCYC plan submission (days)	Meets Timeliness of Submission Standard
1					28	
2					28	
3					28	
4					28	
5					28	
6					28	
7					28	
8					28	
9					28	
10					28	
11					28	
12					28	
13					28	
14					28	
15					28	
16					28	
17					28	
18					28	
19					28	
20					28	

**Suggested New Referral Log**

							Report 4	
0	1	2	12	13	14	15	16	
Row No.	Client Name	Client MID	Date of Receipt of Treatment Plan Authorization	Date of Initiation of Direct Services	Days from Authorization to Initiation of Services	Standard: Timeliness of service initiation for new clients (days)	Meets Timeliness of Initiation of Services Standard	
1						21		
2						21		
3						21		
4						21		
5						21		
6						21		
7						21		
8						21		
9						21		
10						21		
11						21		
12						21		
13						21		
14						21		
15						21		
16						21		
17						21		
18						21		
19						21		
20						21		