Cornerstone Behavioral Healthcare
Section 22. Mental Health Programs

DEFINITIONS/ABBREVIATIONS

- **Adult Community Support-** Rehabilitative services to promote recovery, promote integration into the community, and help client support their current living situation
- **Assessment**: The process of identifying a child and family's strengths, problems and service needs for the purpose of developing the child and/or family's plan.
- **BHH:** Behavioral Health Homes: a team-based model of care for individuals with an ongoing mental health diagnosis per MaineCare Section 92
- **BHHO:** Behavioral Health Home Organization; Organization providing BHH services
- **CANS**: Child and Adolescent Needs and Strengths; screening tool
- **Case Management-** Program to help clients identify their needs and coordinate services to address them
- **CBH:** Cornerstone Behavioral Healthcare
- **Child Behavioral Health Services (CBHS):** facilitates the provision of services for the benefit of Maine children, youth, and families
- **IA:** Initial Assessment
- **Individual Support Plan (ISP):** A comprehensive plan of care for the child and family that is based on an assessment of strengths and needs across the life domain areas, from which specific goals and measurable objectives are developed. The identified goals and objectives should be appropriate to the child and family's cultural needs.
- **Individual Treatment Plan (ITP):** The plan of care for a specific service developed by the treatment team in consultation with the family. The ITP uses a strengths-based and culturally competent approach to assess the treatment needs of a child and, when appropriate, her/her family circumstances. The ITP must be appropriate to the developmental level of the child and shall address all the domains of a child's life. When there is an ITP for identified service(s), it should be referenced in the ISP.
- **Memorandum of Understanding (MOU):** Written agreement between a Health Home provider and a Behavioral Health Home provider that governs the relationship between the two
- **Targeted Case Management (TCM)-** A child-centered, family-focused, team-based approach to coordinate services for children

A. **Admission criteria**. See Section 7.C
B. **Waiting lists and capacity management**. See Section 7.E
C. **Personnel.** See Section 13.F Staffing
D. **Community support services module.**
   1. **Case Management** - See Sec 22.H
   2. **Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations** N/A
   3. **ACT**: N/A
E. **Crisis services module.** N/A
F. **Outpatient Services** – Section 65. CBH offers Medication Management, Outpatient Therapy and Counseling, and Psychological Testing and Evaluation
   1. **Medication Management Services**: Medication Management Services are services directly related to the psychiatric evaluation, prescribing, administration, education, and/or monitoring of medications intended for the treatment and management of mental health disorders, substance use disorders, and/or

co-occurring disorders. These services include treatment conducted by a licensed provider within their declared scope of practice.

a. CBH services adults and children aged 5 and over.

2. **Outpatient Therapy and Counseling:** Outpatient services include, but are not limited to:
   a. psychological assessment, outpatient therapy, outpatient counseling, geriatric services, sex offender treatment, trauma recovery services, specialized group services, or family psychoeducational treatment.
   b. Services are offered to children, adolescents, and adults.
   c. Outpatient Therapy -Mental Health, Substance Use Disorder Counseling, and Co-occurring Therapy.

      i. Outpatient Services are professional assessment, counseling, and therapeutic medically necessary services to improve functioning, address symptoms, relieve excess stress, and promote positive orientation and growth that facilitate increased integrated and independent levels of functioning.
      ii. These services include treatment conducted by a licensed or certified professional, and consists of counseling and therapeutic services.
      iii. Services are delivered through planned interaction using physiological, psychological, and sociological concepts, and techniques and processes of evaluation and intervention.

3. Co-occurring Services are integrated services provided to a client with both a mental health and a substance use disorder diagnosis. This includes persistent disorders of either type in remission, a substance-related or -induced mental health disorder, and a diagnosable disorder that co-occurs with interacting symptoms of the other disorder. Each diagnosis is considered primary and is assessed, described, and treated concurrently. Co-occurring Services consist of a range of integrated, appropriately matched interventions that may include comprehensive assessment, treatment, and relapse prevention strategies that may be combined within the context of a single treatment relationship. Co-occurring Services also include addressing family therapy or counseling issues involving mental health, substance use, or other disorders.
   a. Comprehensive assessment will be conducted by a qualified mental health professional to determine service needs, including those activities that focus on diagnosis and the identification of the need for any medical, educational, social or other services. Assessment must be conducted through contact with the client and, where appropriate, consultation with other providers and with the client's family. The assessment will determine the need for treatment and/or referral, and establishes the appropriate intensity and level of care. For more information regarding assessments see Section 8 (Comprehensive Client Assessments).
   b. Service plans must be completed within thirty (30) days from admission and reviewed every twelve (12) visits or annually, whichever comes first. See Section 9 (Client Service Plan) for more information regarding client service plans.

4. **Intensive Outpatient Program IOP:** N/A

G. **Mental health residential services module**. N/A

H. **<u>Case Management: Adult and Child</u>**: Case management services are services to identify the medical, social, educational, housing, transportation, and other needs of eligible clients; identify the services necessary to meet those needs; and facilitate access to those services. Case management consists of intake/assessment, plan of care development, coordination/advocacy, monitoring, and evaluation. Case

management services are offered to adults and children under the following programs: Adult Community Support, Targeted Children's Case Management, and Behavioral Health Homes. CBH encourages individuals to utilize peer and family supports. During intake, assessment, and quarterly/annual review, needs will be identified and information about resources will be provided. As needed, staff will help make referrals to local community resources and social support services, including those that provide support in self-management, to assist clients and their families in overcoming barriers to care and meeting health and recovery goals. Program descriptions are as follows:

1. **Adult Community Support and Integration, Section 17 MaineCare Manual.** Community Support Services means rehabilitative services, provided pursuant to an individual's service plan, that promote a client's recovery and integration into the community and sustain the client in his or her current living situation. Reassessments shall occur at least annually in order to ensure ongoing eligibility for services provided herein. Eligibility verification shall be included in the client's record.
2. **Targeted Children's Case Management Sec 13.12 of MaineCare Manual:** CBH offers TCM which utilize a child-centered and family-focused process to develop and coordinate individual support plans and monitor services to be provided to a child and their family or guardian. This process is undertaken with participation and consultation from the family, a multidisciplinary team of professionals, and other support people chosen by the family, child and team.
    a. Children who have experienced trauma, abuse, neglect, and maltreatment may present with social, emotional, and behavioral challenges that can range from acute to long-term. Due to the significant and known risks associated with early onset of emotional and behavioral difficulties, systematic, timely, effective and reliable identification and intervention is essential. Conversely, children who are not in need of clinical interventions should not be subjected to unnecessary or contraindicated treatment due to risk of negative outcomes.
    b. TCM involves working with families to assess needs and develop plans of support, thereby assisting families in meeting the developmental and therapeutic needs of their children. Family members and natural supports must be engaged in both the assessment and planning process in order for efforts to be effective.
    c. CBH affirms that Practice Model affirms strengths of the child and family as well as needs. It focuses on assessing the signs of behavioral, developmental, and/or mental health needs of the child in order to capitalize upon strengths, while providing the family with the full level of support they need in order to reduce risk and danger, and maximize well-being of the child. This policy promotes family engagement and a team approach to planning and intervention.
    d. TCM will include preventive care, diagnosis, and treatment of identified needs. The provision of case management is defined as services that assist eligible individuals in gaining access to medical, social, educational, and other services. "Eligible individuals" refers to children with behavioral health needs.
    e. TCM consists of:
        - Assessing the child's needs;
        - Coordinating the delivery of appropriate services as defined in the assessment;
        - Assisting the child and family in accessing appropriate services;

- Monitoring the child and family's progress by making referrals, tracking appointments, following up on services rendered, and periodically reassessing the child's and family's needs;
- Advocating on behalf of the child and family;
- Consulting with service providers or collateral contacts to determine the status or progress of the child and family's plan;
- Arranging for crisis assistance, such as coordinating emergency services; and
- Continually assessing for safety, risk & danger.

f. The ISP must specify the following:
   - Service components to be provided;
   - Names and titles of those who will be accountable for provision of the service;
   - Frequency and duration of each service component;
   - Expected duration of treatment; and
   - Expected short- and long-range treatment and/or rehabilitative goals or outcomes of the services.

g. CBH will provide only medically necessary services, defined as preventing, diagnosing, or treating conditions in a manner that is:
   (i) Consistent with generally accepted standards of medical practice;
   (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration;
   (iii) Demonstrated through scientific evidence to be effective in improving health outcomes or is generally accepted as representative of "best practice" in the medical profession;
   (iv) Not primarily for the convenience of the child, their family, physician, or health care practitioner.

h. CBH will utilize the screening tools required and provided by Licensing and DHHS Office of Behavioral Health.
   i. A comprehensive behavioral health psychosocial screening must be administered to all children receiving TCM services.
   ii. The assessment will be:
      1. Completed within 30 days of opening the case for services;
      2. Obtained through face-to-face contact with the child and at least one parent or caregiver; and
      3. Updated annually (or sooner should an identified need arise) for those children who do not carry a documented behavioral health diagnosis.
   iii. CANS-A universal validated screening tool from DHHS to appropriately identify and address the emotional and behavioral health needs of children who receive TCM services.
      - Children ages 4 through 20: The CANS will be used to screen children in this age range for clinically significant behavioral, cognitive, and emotional challenges. The case manager is responsible for administering and scoring the screening tool.
      - Children up to age 4: All children in this age range will be referred to Child Development Services (CDS) for screening and evaluation.

i. Service Planning

i. Children identified in need of further assessment and treatment will be referred to the most appropriate services based on their specific and unique needs. The case manager will work with the family, child, and the family team to identify the specific needs and develop a plan to meet these needs.

j. Documentation Guidelines:
   i. The statement of needs and the plan to meet the identified needs will be clearly described in the IA and ISP.
   ii. Need statements will be as specific, child-centered, culturally appropriate, and strengths-based as possible.
   iii. Each need statement will be followed by an outcome statement, which provides a clear and measurable picture of what will happen when the child/family successfully meets the need.
   iv. A specific plan to meet the need with a target date of completion will be clearly and concisely described.
   v. The service plan will be developed within 30 days from the intake and determination of eligibility, and updated every 90 days or as the needs change. Service planning should take place in the context of a Family Team Meeting with input and participation from team members. The plan should be monitored monthly during contact with the child and family/caregiver, and progress tracked and documented in progress notes.

k. Care Coordination
   i. The case manager has primary responsibility for coordinating identified supports, when and from what provider evaluation and treatment will be provided based on the assessment, provider input, child and family determination at intake and at care review. This decision is made following consultation with Behavioral Health Services provider, the family and/or primary caregiver, the child's physician, and the family team. These decisions will be made with full team input.
   ii. The case manager will be responsible for scheduling, arranging services, and transportation as necessary. The family should take part in the treatment whenever clinically indicated.

l. Transition Planning
   i. Efficient and sensitive transition of case management services is essential. The Family Team Meeting planning process will be the method for transitioning children to adult or other case management services. TCM services require transition planning and methods to facilitate the transition
   ii. If the child is transferred in Child Welfare Custody, case management services will be transferred from CBH to the DHHS Child Welfare caseworker. Prior to the transition of services, the caseworker will meet with the contracted case manager and family/caregiver to review the Individual Support Plan (ISP) and devise a plan to transition ISP goals to the DHHS caseworker to be documented in the Family and/ or Child Case Plan. A Family Team Meeting will be convened within the timeframes in policy or as soon as is practicable to effect the transition to the DHHS caseworker.
   iii. Cases in active status where the plan is for a child and family to be discharged from Child Welfare case management within the next three (3) months, the caseworker and the family team may decide it is in the child's best interest to remain with the present Targeted Case Manager to ensure continuity of care at case closure. Cases receiving both case management services (child

welfare and Targeted Case Management) require review and approval by the casework supervisor.

iv. Children with special circumstances (such as a chronic or severe medical condition) or who are members of a special population (such as deaf/hard of hearing, refugee status, intellectual disability, or a diagnosis of Autism Spectrum Disorder) may benefit from the services of both a Targeted Case Manager and the DHHS caseworker. The decision to provide dual case management should be based on the child's unique needs and made in the context of the Family Team Meeting process. If the Family Team Meeting does not reach consensus as to dual versus single case management, consultation about the child's needs should be sought from CBHS and the child's clinician/therapist, if they have one. If consensus cannot be reached from the consultation process, the final decision rests with the legal representative. Families with open Child Protective Services cases who retain custody of their children have the right to choose the case management provider for their child.

m. Case Closure/Discharge

i. Discharge planning begins at admission. Discharge or the case closure process should be discussed regularly with the family and the team from the onset of service. Case managers will monitor the child's mental, behavioral, and developmental health needs throughout the progression of a case via regular case contacts, family team meetings, treatment team meetings, case plan reviews, and collateral contacts. In preparation for closure, case managers also coach the family/caregiver in meeting the child's behavioral health needs and arranging for services. Behavioral health needs that are met are documented in notes, ISP, and annual and Discharge Assessments. Upon the family's exit from services, the Discharge Summary will include a summary of the child's course of service/treatment, a description of any ongoing needs at discharge, and the plan to meet these needs in the community. The family's role in meeting these needs should be outlined as well.

ii. The Family Team Meeting process will be used to plan for a child and family's continuing need for services. Children who will continue to need adult or other types of case management following case closure will be connected to an appropriate Case Management services by the caseworker within 30 days from the projected closure date to ensure continuity of care.

iii. For youth requiring transition to adult services, CBH will follow the Protocol for the Coordination of Transition of Children under OCFS Care to the Adult Service Programs.

3. **Behavioral Health Home Sec 92 services:** CBH is a qualified BHHO that is licensed as community-based mental health organization in Maine. CBH is approved by MaineCare to provide Section 92 services for children and adults eligible for such services.

a. BHH is a team-based model of care that includes the following:

i. Psychiatric Consultant
ii. Nurse Care Manager
iii. Clinical Team Leader
iv. Health Home Coordinator (Case Manager)
v. Certified Peer Specialists (youth and adult)
vi. Medical Consultant

b. A BHHO works with Health Home Providers in its area to achieve integrated care. Providers will have MOU's established to govern the relationship and integration. Clients must be informed and consent to the service.
c. Core Standards are:
   i. **Demonstrated Leadership** – The BHHO identifies at least one (1) Clinical Team Leader within the BHHO who implements and oversees the Core Standards. The Clinical Team Leader(s) work with other providers and staff in the BHHO to build a team-based approach to care, continually examine the processes and structures to improve care, and review data on the performance of the BHHO.
   ii. **Team-Based Approach to Care** – The BHHO has implemented a team-based approach to care delivery that includes expanding the roles of non-licensed team professionals and includes CIPSS as leaders and partners in the provision of care. The BHHO utilizes non-licensed staff to improve access, efficiency, and client engagement in specific ways, including one or more of the following:
      - Through clear identification of roles and responsibilities;
      - Training on and integration of CIPSS as meaningful partners in service delivery;
      - Regular team meetings.
   iii. Population Risk Stratification and Management – The BHHO has adopted processes to identify and stratify clients across their population who are at risk of hospitalization, institutionalization, involvement with law enforcement, or job or home loss that have occurred as a result of the client's SPMI or SED. The BHHO has adopted procedures that direct resources or care processes to reduce those risks.
   iv. Enhanced Access – The BHHO enhances access to services for their clients, including:
      - An on call or answering service for BHH clients to reach a member of the organization or an authorized entity twenty-four (24) hours a day to address and triage their needs
      - Twenty-four (24) hour access to client's records
      - Monitoring and ensuring this enhanced access to care
   v. **Comprehensive Client/Family Directed Care Planning** – The BHHO has processes in place to ensure that client voice and choice is reflected in Plan of Care development. These processes include:
      - Wraparound principles for children with SED and their families.
      - Practice guidelines for recovery-oriented care.
   vi. **Behavioral-Physical Health Integration** – CBH has completed a baseline assessment of its behavioral-physical health integration capacity during its first year of participation as a BHHO. Using results from this baseline assessment, CBH has implemented one or more specific improvements to integrate behavioral and physical health care.
   vii. **Inclusion of Clients and Families** – CBH includes clients and their families as documented and regular participants at leadership meetings, and/or CBH has in place a client-driven process to identify needs and solutions for improving services.
      - CBH has processes in place to support clients and families to participate in leadership and/or advisory activities
      - CBH has implemented systems to gather client and family input at least annually (through mail surveys, phone surveys, point of care questionnaires, focus groups, or other methods); and

- CBH has processes in place to design and implement changes that address needs and gaps in care identified via client and family input.

viii. **Connection to Community Resources and Social Support Services** – CBH has processes in place to identify available local community resources and social supports, and make referrals to them, including those that provide support in self-management, to assist clients in overcoming barriers to care and meeting health and recovery goals.

ix. **Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-Effective Use of Healthcare Services** – CBH has processes in place to reduce wasteful spending of healthcare resources and improve the cost-effective use of healthcare services, as evidenced by at least one initiative that targets waste reduction, such as:
- Reducing avoidable hospitalizations;
- Reducing avoidable visits to the emergency department;
- Working with specialists to develop new models of specialty consultation that improve client experience and quality of care, while reducing unnecessary use of services; and
- Directing referrals to specialists who consistently demonstrate high quality and cost-efficient use of resources.

x. **Integration of Health Information Technology** – CBH uses an electronic data system that includes identifiers and utilization data about clients. Client data is used for monitoring, tracking, and indicating levels of care complexity for the purpose of improving client care. The system is used to support client care, including one or more of the following:
- The documentation of need and monitoring clinical care
- Supporting implementation and use of evidence-based practice guidelines;
- Developing Plans of Care and related coordination; and
- Determining outcomes (e.g., clinical, functional, recovery, satisfaction, and cost outcomes).

Sharon Jordan
_____ 5/11/2024
Clinical Director Date