Child and Family Treatment and Support Services (CFTSS) Principles and Documentation

A REVIEW OF STATE GUIDANCE
Please Note

- Refer to state guidance documents for official guidance.
- Providers should follow internal agency policy and procedures in alignment with state issued guidance and manuals.
- Information is current as of the date of the presentation.
- Slides and recording will be posted to the CTAC website.
Agenda

- Background
- Importance of Documentation
- Golden Thread
- Treatment Planning
- Progress Notes
- Supervisory Review
- Resources
CFTSS Timeline

- January 2019
  - Community Psychiatric Supports & Treatment
  - Other Licensed Practitioner
  - Psychosocial Rehab

- July 2019
  - Family Peer Support Services

- January 2020
  - Crisis Intervention
  - Youth Peer Support & Training
Purpose of Documentation Guidance

- Provides clarity on the principles and documentation requirements in alignment with the Standards of Care
- Reviews best practices that support the practice of treatment planning as a core element of service provision

How to Use the Health Record Documentation Guidance:

- Requirements (e.g., “must”)
- Principles/ Best Practices (e.g., “should”)
  - “Tip Boxes”
- Appendix: “Helpful Guidance”
Importance of Documentation

- Accurate records and documentation:
  - Explicitly and accurately reflects the nature, scope, and detail of the care provided
  - Demonstrates a clinical connection between the behavioral health assessment, medical necessity for a service, treatment plan, progress notes, and subsequent plan reviews (“Golden Thread”)
  - Assists with treatment goals remaining on target by recording the effectiveness and outcomes of therapeutic interventions
  - Demonstrates accountability to the individual receiving services and to county, state and federal authorities
  - Facilitates continuity of care and communication between providers and the child and family
  - Demonstrates the provision of quality mental health care
  - Demonstrates the billable services delivered for reimbursement
Multi-System Community Based Culturally Competent Least Restrictive

Core Principles

Family Focused Developmentally Appropriate Trauma Informed Community Based Multi-System Child Centered Culturally Competent Least Restrictive
The Golden Thread

- Assessment
- Treatment & Services
- Progress Notes
- Discharge Summary
Golden Thread: Considerations

- How is the assessment/reassessment information reflected in the treatment plan? How does it factor into the treatment planning process?
- Do the progress notes clearly link to goals and objectives from the treatment plan?
- Are goals and objectives individualized; based on family voice and choice, assessment, or reassessment?
- Are treatment goals, objectives or overall clinical strategy reviewed and adjusted when the individual is not progressing?
- Is the treatment plan reviewed and adjusted when new high priority issues are identified, or current objectives are achieved?
Treatment Planning for CFTSS
Quality Treatment Plans Are...

- Individualized
- Up to date and evolving
- Grounded in medical necessity
- Built on child and family-strengths
- Developed in partnership
- Written to reflect the vision and priorities of the youth and family
- Based on broad goals and measurable objectives
- Describe the services and interventions
- Clear about the scope, frequency, and anticipated duration of the service
Not Just a Piece of Paper

- The process of writing and making updates and revisions to the plan should engage families in defining their needs, strengths, goals and steps they want to take.

- The treatment plan is a touchstone for an ongoing conversation about what is working, what isn’t working and helps everyone know when goals have been met.

- It is an agreement between the provider and family about what changes need to occur and how they will work together to achieve those changes.
<table>
<thead>
<tr>
<th>Treatment Plan Components</th>
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<tbody>
<tr>
<td>1. Child’s behavioral health diagnosis, where required; or behavioral health challenges/symptoms to be addressed</td>
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<td>2. Child’s needs and strengths</td>
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<td>3. Child’s treatment goals and objectives</td>
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<td>4. Services, service components and interventions (scope)</td>
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<td>5. Frequency and duration of services</td>
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<td>6. Service location(s)</td>
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<td>7. List of other service providers and individuals involved in the child’s care</td>
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<td>8. Safety Plan*</td>
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<td>9. Discharge criteria</td>
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<td>10. Name, title and signature of the staff providing the service</td>
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<td>11. Signature of the child and family/caregiver*</td>
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<td>12. Signature of licensed supervisor (or, for FPSS and YPST a licensed supervisor or a supervisor with an FPA Credential)</td>
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See Reference Manual for additional information
Must be completed by the 4th session or no later than 30 days after admission (first face-to-face).

Formal review must take place, at a minimum, every 180 days. Targeted adjustments to the plan do not replace a formal review.

You can and should revise the plan any time there is a change.
Treatment Plan Reviews

- At least every 180 days
- Assessment of progress on each goal and objective
- Input of the child, family and other service providers
- Signatures or other indication of participation or indication of why the child/family did not participate
- Adjusting and updating goals, objectives and interventions. For cancelled or deferred goals, provide an explanation.
- Signature of licensed practitioner or licensed supervisors (and for FPSS or YPST, a credentialed supervisor)
Integrated Treatment Plan

- Strategy to facilitate service coordination to benefit the family and align service provision.
- Coordination and collaboration can happen through formal team meetings, regular communication among service providers, and thoughtful planning with the family.
- If a child receives multiple services from the same provider agency, the EHR may have the capacity to facilitate an integrated treatment plan.

Ensure proper consents to share information are in the record!
A safety plan is a tool to assist the child and family to recognize and respond to an elevation of symptoms or indication of risk in a safe and effective way.

Established when risk is indicated.

Typically, developed as part of the treatment plan when past and/or current risk factors indicate a likelihood of elevated risk.

Developed in collaboration with the youth and family (and others involved in the child’s treatment).
Safety Plan

- A safety plan is required when crisis-related services are being provided in any of the CFTSS.
- Best practice is for every child to have a basic safety plan with on-call and emergency contact information.
- Reviewed and updated following changes to the child’s behavioral health, mental status
  - For example: change in available resources/supports, change in risk level or risk factors, change in symptoms/functioning, medication changes, precipitating events, hospitalization or discharge from hospital, etc.

*If you are not a licensed clinician and you feel that a child should be evaluated based on safety concerns, refer and link*
Discharge Plan

• Discharge criteria should be identified at admission
• Creates a shared understanding of the changes that need to occur to meet the goals and be ready for discharge
• Outlines the supports and services needed to maintain the gains made and address any new issues that arise following discharge.

Discharge Summary

• Summarizes the care that was provided by CFTSS and supports continuity of care by outlining the child and family’s continuing needs.
• For specific requirements of discharge plan, refer to the guidance document.
Progress Notes
Progress Notes

- A progress note must be completed for:
  - Services delivered
    - Direct service to child and/or family
    - Coordination or Collaborative Contact on behalf of child/family
  - Significant or unexpected events
- Medicaid requires that progress notes be contemporaneous with service provision
Progress Note Components

To meet CFTSS standards, a Progress Note must document:

• Standard demographic information (e.g., name, DOB, identification number, etc.)
• Type of contact (e.g., face-to-face)
• Modality (e.g., individual, family or group session)
• Service provided
• Duration of service; (session start and end time e.g., 10:00am-11:00am)
• Name of person/agency providing the service
Progress Note Components

- Date of service
- Location in which service was provided
- Participants (to whom the service was provided)
- Interventions provided/utilized
- The child/youth’s and family/caregiver’s response to the interventions
- Goal(s) and objective(s) that were addressed and progress made
- Plan of action (e.g. plan for the continuing work; follow up plan needed to address any changes in functioning or symptoms; safety measures to be taken; rationale for changes or additions needed to current goals, objectives and interventions)
Progress Notes for Groups

▶ In addition to components mentioned, Group progress notes must clearly
  ▪ Indicate “group” as the service modality provided
  ▪ Detail number of participants (including any non-CFTSS children present in the group)
  ▪ Identify number of service providers present
▶ Group service must be clearly identified as an intervention in the treatment plan and associated with the specific objectives.
▶ A group progress note must be written for each group session and each participant.
Supervisory Review
Supervisory Review

Supervisors are expected to implement a process for review of documentation as a component of supervision to assure completeness, appropriateness, quality and compliance.

The development of a CFTSS treatment plan requires the review, approval and signature of the licensed practitioner/supervisor (if different from the provider).

Supervisory signature demonstrates supervisory review and approval of the treatment plan, indicating the plan's appropriateness in addressing the presenting needs of the child and the specific service(s) to be provided.
Supervisory Review

- Each CFTSS provider agency is expected to develop and implement a quality assurance process to facilitate improved documentation practices.

- The overall documentation of each staff is periodically reviewed, including all aspects of the health record, to identify strengths and needed areas for development and training.
Additional Documentation

- Information relevant to the child’s behavioral and medical health history
- Readily accessible emergency medical information
- Service orientation documentation, in alignment with Standards of Care
Please send questions to: dcfs@omh.ny.gov
State Mailboxes

NYS OMH Managed Care Mailbox
OMH-MC-Children@omh.ny.gov

NYS OASAS Mailbox:
PICM@oasas.ny.gov

NYSDOH Health Homes for Children:
HHSC@health.ny.gov

NYS OCFS Mailbox:
OCFS-Managed-Care@ocfs.ny.gov
State Guidance Documents

Child and Family Treatment and Support Services Provider Manual

CFTSS Health Record Documentation
Other Related Resources

Children’s Behavioral Health Transition to Managed Care

Subscribe to Stay Informed

- Subscribe to the Children’s Managed Care Listserv
  http://www.omh.ny.gov/omhweb/childservice/

- Subscribe to DOH Health Home Listserv
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

- Health Home Bureau Mail Log (BML)
  https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
Tools

Select the Tools Tab at www.ctacny.org

- **Managed Care Plan Matrix** – comprehensive resource for MCO contact information relevant to adults and children

- **Billing Tool** – Children System specific updates – coming soon!

- **Output to Outcomes Database** – access to standardized outcome measurement tools and metrics (database) designed to facilitate and improve use of evidence based practices.
Contact CTAC

Please send questions to: ctac.info@nyu.edu

Logistical questions usually receive a response in 1 business day or less.

Longer & more complicated questions can take longer.

We appreciate your interest and patience!

Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access resources.
Thank You

- Shannon Fortran | Division of Integrated Community Services for Children and Families, New York State Office of Mental Health
- Diana Manganelli | Division of Integrated Community Services for Children and Families, New York State Office of Mental Health
- Yvette Kelly | Director of Children's Services and Healthcare Innovation - CTAC/MCTAC
- Anne Kuppinger | Senior Research Coordinator - CTAC/MCTAC