**Centers for Youth and Families**
**Response Packet Bid No. 710-19-1024**
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**STATE OF ARKANSAS**
**OFFICE OF PROCUREMENT**
**ARKANSAS DEPARTMENT OF HUMAN SERVICES**
700 Main Street
Little Rock, Arkansas 72203

# *FINAL RESPONSE PACKET*
# *710-19-1024*

## CAUTION TO VENDOR

Vendor's failure to submit required items and/or information as specified in the *Bid Solicitation Document* **shall** result in disqualification.

# SIGNATURE PAGE

*Type or Print the following information.*

| PROSPECTIVE CONTRACTOR'S INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| Company: | Centers for Youth and Families | | | | | |
| Address: | PO Box 251970 | | | | | |
| City: | Little Rock | | State: | AR | Zip Code: | 72225 |
| Business Designation: | ☐ Individual ☐ Partnership | ☐ Sole Proprietorship ☐ Corporation | | ☐ Public Service Corp ☑ Nonprofit | | |
| Minority and Women-Owned Designation*: | ☑ Not Applicable ☐ African American | ☐ American Indian ☐ Hispanic American | ☐ Asian American ☐ Pacific Islander American | ☐ Service Disabled Veteran ☐ Women-Owned | | |
| | AR Certification #: _____ | | * See *Minority and Women-Owned Business Policy* | | | |

| PROSPECTIVE CONTRACTOR CONTACT INFORMATION<br>*Provide contact information to be used for bid solicitation related matters.* | | | |
|---|---|---|---|
| Contact Person: | Lindsey Cooper | Title: | Grants Officer |
| Phone: | 501-660-6869 | Alternate Phone: | 501-666-8686 |
| Email: | lcooper@cfyf.org | | |

## CONFIRMATION OF REDACTED COPY

☐ YES, a redacted copy of submission documents is enclosed.

☑ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

*Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.*

## ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

## ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

☑ Prospective Contractor does not and will not boycott Israel.

***An official authorized to bind the Prospective Contractor to a resultant contract must sign below.***

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* **will cause the Prospective Contractor's bid to be disqualified:**

**Authorized Signature:** Melissa Dawson *Use Ink Only.* **Title:** President/CEO

**Printed/Typed Name:** Melissa Dawson **Date:** March 14, 2019

# SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation. ***Use Ink Only***

| | | | |
|---|---|---|---|
| **Vendor Name:** | Centers for Youth and Families | **Date:** | March 14, 2019 |
| **Authorized Signature:** | Melissa Dawson | **Title:** | President/CEO |
| **Print/Type Name:** | Melisssa Dawson | | |

# SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation. ***Use Ink Only***

| | | | |
|---|---|---|---|
| **Vendor Name:** | Centers for Youth and Families | **Date:** | March 14, 2019 |
| **Authorized Signature:** | Melissa Dawson | **Title:** | President/CEO |
| **Print/Type Name:** | Melissa Dawson | | |

# SECTION 3,4,5 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation. ***Use Ink Only***

| | | | |
|---|---|---|---|
| **Vendor Name:** | Centers for Youth and Families | **Date:** | March 14, 2019 |
| **Authorized Signature:** | Melissa Dawson | **Title:** | President/CEO |
| **Print/Type Name:** | Melissa Dawson | | |

# PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

**PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.**

*Type or Print the following information*

| Subcontractor's Company Name | Street Address | City, State, ZIP |
|---|---|---|
| Recovery Centers of Arkansas | 14913 Cooper Orbit Road | Little Rock, AR 72223 |
| Little Rock Community Mental Health Center | 1100 N University Ave #200 | Little Rock, AR 72207 |
| Birch Tree Communities, Inc. | 1781 Old Hot Springs Highway | Benton, AR 72018 |
| Ouachiata Behavioral Health | 125 Wellness Way | Hot Springs, AR 71913 |
| Pulaski County Crisis Stabilization Unit | 300 W Roosevelt Rd. | Little Rock, AR 72204 |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

By signature below, vendor agrees to and **shall** fully comply with all Requirements related to subcontractors as shown in the bid solicitation.

| | | | |
|---|---|---|---|
| **Vendor Name:** | Centers for Youth and Families | **Date:** | March 14, 2019 |
| **Authorized Signature:** | Melissa Dawson | **Title:** | President/CEO |
| **Print/Type Name:** | Melissa Dawson | | |

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203
501-320-6511

**ADDENDUM 1**

**DATE:** February 25, 2019
**SUBJECT:** 710-19-1024 Crisis and Forensic Mental Health Services

The following change(s) to the above referenced Invitation for Bid for DHS has been made as designated below:

**Change of specification(s)**
_____ Additional specification(s)
_____ Change of bid opening date and time
_____ Cancellation of bid
_____X___ Other – Removing the following language from section 2.3.2 C, page 26, of the RFQ.

*** Information provided on forensic services is under review and may be subject to revision for future posting.**

**BID OPENING DATE AND TIME**

Bid opening date and time ***will not be changed.***

---

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED. THE BID ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE BID NUMBER, DATE AND HOUR OF BID OPENING AND BIDDER'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE DEPARTMENT OF HUMAN SERVICES.

If you have questions, please contact the buyer at nawania.williams@dhs.arkansas.gov or 501-320-6511

Melena Dawson — 3/14/19
Vendor Signature — Date

Centers for Youth and Families
Company

# SELECTION OF REGIONS

**Instructions:** Bidder may submit proposals for up to two regions indicated in Attachment G: Map of Regions. Bidder must list selected regions in order of preference using the table below.

**NOTICE TO BIDDERS:** Bidders submitting proposals for multiple regions and who do not assign preference rankings for all regions bid may be awarded a region at the discretion of DHS.

| Bidder Preference | Region by Number (as shown in Attachment G: Map of Regions) |
|---|---|
| First (1st) Choice | Region #: 6 |
| Second (2nd) Choice | Region #: |
| Third (3rd) Choice | Region #: |
| Fourth (4th) Choice | Region #: |
| Fifth (5th) Choice | Region #: |
| Sixth (6th) Choice | Region #: |
| Seventh (7th) Choice | Region #: |
| Eighth (8th) Choice | Region #: |
| Ninth (9th) Choice | Region #: |
| Tenth (10th) Choice | Region #: |
| Eleventh (11th) Choice | Region #: |
| Twelfth (12th) Choice | Region #: |

# CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

F-1

Failure to complete all the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

**SUBCONTRACTOR:** ☐ YES ☒ NO

**SUBCONTRACTOR NAME:** Centers for Youth and Famlies

**Contractor for which this is a subcontractor:**

**Estimated dollar amount of subcontract:**

IS THIS FOR: ☐ **Goods?** ☐ **Services** ☐ **Both?**

**TAXPAYER ID NAME:** 71-0415350

**YOUR LAST NAME:** Dawson **FIRST NAME:** Melissa **MI:**

**ADDRESS:** PO BOx 251970

**CITY:** Little Rock **STATE:** AR **ZIP CODE:** 72225 **COUNTRY:** UNITED STATES OF AMERICA

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

## FOR INDIVIDUALS*

**Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse is a current or former: Member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:**

| Position Held | Mark (✓) | | Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.] | For How Long? | | What is the person(s) name and how are they related to you? (i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.) | |
|---|---|---|---|---|---|---|---|
| | Current | Former | | From MM/YY | To MM/YY | Person's name(s) | Relation |
| General Assembly | ☐ | ☐ | | | | | |
| Constitutional Officer | ☐ | ☐ | | | | | |
| State Board or Commission Member | ☐ | ☐ | | | | | |
| State Employee | ☐ | ☐ | | | | | |

☐ **None of the above applies**

## FOR A VENDOR (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

| Position Held | Mark (✓) | | Name of Position of Job Held (senator, representative, name of board/commission, data entry, etc. | For How Long? | | What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control? | | |
|---|---|---|---|---|---|---|---|---|
| | Current | Former | | From MM/YY | To MM/YY | Person's name(s) | Ownership Interest (%) | Position of Control |
| General Assembly | ☐ | ☐ | | | | | | |
| Constitutional Officer | ☐ | ☐ | | | | | | |
| State Board or Commission Member | ☒ | ☐ | U of A-Board of Trustees Member | 02/16 | 03/19 | Kelly Eichler | | Board Member |
| State Employee | ☒ | ☐ | ACHI-Director of Policy | 08/95 | 03/19 | Suzanne McCarthy | | Board Member |

☐ **None of the above applies**

* NOTE: PLEASE LIST ADDITIONAL DISCLOSURES ON SEPARATE SHEET OF PAPER IF MORE SPACE IS NEEDED

# CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM F-2

***Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.***

**As an additional condition of obtaining, extending, amending, or renewing a contract with a state agency I agree as follows:**

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.
2. I will include the following language as a part of any agreement with a subcontractor:

   ***Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.***

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

*I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.*

**Signature** Melissa Dawson **Title** Melissa Dawson **Date** March 14, 2019

**Vendor Contact Person** Lindsey Cooper **Title** Grants Officer **Phone No.** 501-660-6869

***AGENCY USE ONLY***

| Agency Number | Agency Name | Agency Contact Person | Contact Phone No. | Contract or Grant No. |
|---|---|---|---|---|
| 0710 | Department of Human Services | | | |

** NOTE: PLEASE LIST ADDITIONAL DISCLOSURES ON SEPARATE SHEET OF PAPER IF MORE SPACE IS NEEDED*

# EQUAL OPPORTUNITY EMPLOYMENT HRD-21

## I. PURPOSE

To affirm Centers For Youth And Families' position regarding nondiscrimination in all matters relating to employment.

## II. POLICY

The Centers will not discriminate against its employees or applicants for employment because of sex, sexual preference or orientation, race, color, religious opinions or affiliations, national origin, age, disability or veteran status provided they are qualified for employment for existing positions and that with reasonable accommodation can perform the essential functions of the job in question pursuant to Section 504 of the Rehabilitation Act of 1973 or veteran status.

## III. PROCEDURE

**A.** All recruitment sources are notified by Human Resources of our equal employment opportunity policy.

**B.** All classified advertising includes the phrase "Equal Opportunity Employer".

**C.** The Centers maintains common facilities such as restrooms (gender excepted), lounges, cafeteria, and drinking fountains on a nonsegregated basis.

**D.** Supervisory personnel ensure that the principles of nondiscrimination are implemented in all policies and procedures affecting the employee's status with The Centers to include, but not limited to, recruitment, selection, interviewing, training, promotion, retention, discipline, termination, compensation, benefits, transfer, layoff, recall from layoff, and educational, social or recreational programs.

**E.** Management ensures this policy is communicated on a continuing basis to include, but not limited to employees engaged in employment, placement and training.

## Technical Proposal

## E.1 VENDOR QUALIFICATIONS

### E.1.A. Region

Centers for Youth and Families (The Centers) in conjunction with Little Rock Community Mental Health Center (LRCMHC) is proposing to provide services in this response packet in Region 6 of Arkansas.

### E.1.B. Background narrative

**a. Date established.**

Founded as an orphanage in 1884, Centers for Youth and Families is the oldest continuously operating not-for-profit in Arkansas. Throughout our evolution from the Children's Aid Society in 1884, to the Little Rock Orphans' Home in 1907, to the Elizabeth Mitchell Memorial Home in 1947 and, finally, to Centers for Youth and Families in 1987, the mission of caring has remained unchanged: "*to provide specialized prevention, intervention and treatment services that promote emotional and social wellness for children and families in Arkansas.*"

The Centers is an established local community service provider and is exempt from Federal Income Tax under section 501(c)(3) of the Internal Revenue Code. We are accredited by the Joint Commission on the Accreditation of Healthcare Organizations, a member of the Mental Health Council of Arkansas, approved as a special education resource by the Arkansas Child Welfare Agency Review Board and licensed by the Arkansas Department of Health as an approved psychiatric facility. Such accreditation demonstrates The Centers' commitment to continuously improve service quality and to focus on the satisfaction of the individuals served. As an OBHS provider in Region 6, The Centers provides care, treatment and services to individuals who have a behavioral health diagnosis as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-5).

The Centers full continuum of care demonstrates a No Wrong Door system of networks which provides individuals with a universal gateway to community services and programs that enables individuals to approach the agency with the problem they need to address. Our long-standing relationship with Little Rock Community Mental Health Center (LRCMHC) equips us with the tools needed to fulfill the requirements of this RFQ by providing a full continuum of community behavioral health services for both adults with serious mental illness and children and youth with serious emotional disturbance.

**b. List of Board of Directors**

The Centers' 2018-2019 Board of Directors:

Mark Allison, Attorney, Dover Dixon Horne, PLLC

Carole Baxter, CEO, Recovery Centers of Arkansas
Peyton Bishop, Community Volunteer
Melissa Dawson, Centers for Youth and Families, President/CEO
Kelly Eichler, Community Volunteer
Jo Evelyn Elston, Little Rock School District
Rick Fleetwood, CEO, Snell Prosthetic & Orthotic
Chad May, Armor Bank, *Chair*
Suzanne McCarthy, Policy Director, Arkansas Center for Health Improvement, *Vice-Chair*
Lori Montgomery, Pediatrician, Arkansas Pediatric Clinic
John Neumeier, Practice Plus, *Treasurer*
Don Pfeifer, Community Volunteer
Barry Simon, President, DataMax, *Member-At-Large*
Kim Stafford, Essick Air Products
Matt Suffern, Attorney, Entergy, *Secretary*

**c. Total number of employees.**

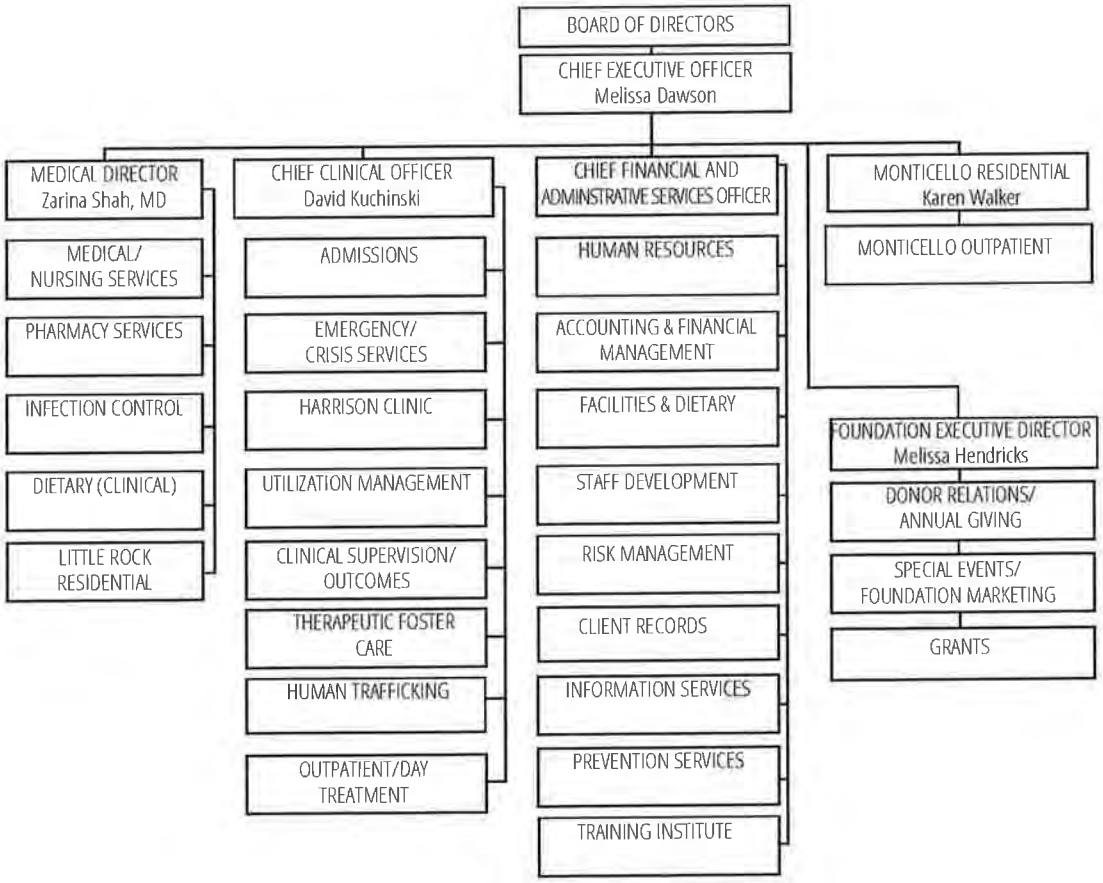
As a behavioral health services provider, The Centers employs staff who are able and available to deliver appropriate and adequate services, both in the clinic setting and within the community. A total of 252 professionals are employed by The Centers (165 full-time and 87 part-time), all of whom are trained in the trauma-informed model of care. Of these 252 employees, 42 are licensed mental health professionals, 115 are certified qualified behavioral health providers, 2 are licensed medical doctors (psychiatrists), 3 are advanced practice registered nurses and 31 are registered nurses/licensed practical nurses. The remaining 59 professionals include support, foundation and administrative staff.

All clinical and medical staff are required to maintain their licenses in accordance with each licensing Board. All qualified behavioral health providers are required to complete 30 hours of annual training. Training topics include CPR, handle with care, first aid & safety, mandated reporting of child abuse/neglect, documentation requirements, confidentiality, cultural competency, cultural diversity and HIPAA (Health Insurance Portability and Accountability Act).

The Centers follows Neal Adams' Treatment Planning for Person-Centered Care which guides our clinician team in how to engage clients in building and enacting collaborative treatment plans that result in better outcomes. We follow this clinical service delivery module to organize and conduct the recovery plan meeting, prepare and engage individuals in the treatment planning process and help with goal setting and evaluate and improve the results.

**d. Organization chart.**

# Centers for Youth & Families
## Organizational Chart




*(Refer to Attachment E for Little Rock Community Mental Health Center's Organization Chart)*

**E.1.C. Past Performance. Describe your experience similar to that which is sought by this RFQ within the past 3 years. Include: a description of the work performed, including if this work was provided for DHS.**

The Centers is a non-profit organization committed to building healthy children, families and communities in Arkansas through prevention, intervention and treatment programs. Our professional staff help adults with serious mental illness and children and adolescents with serious emotional disturbance live productive lives, equipping them with the tools to live successfully in the community and serve as a guiding force in removing the stigmas associated with mental illness. Care and services are provided in such a way that individuals served have a

sense of dignity, autonomy, positive self-regard, consideration of their civil rights and involvement in the provision of their own care and services. This involvement considers the individual strengths, weaknesses, resources, social environment and the requirement and expectations of the service providers and individuals they serve.

The Centers is a premiere provider of comprehensive behavioral health and emergency services for children and adults in central Arkansas. Our agency has extensive experience within the past (3) years providing services similar to that which is sought by this RFQ. Treatment services and programming include crisis screenings, psychiatric residential treatment for children and adolescents, day treatment for children and adolescents, outpatient counseling, discharge planning, forensic outpatient restoration program, DYS transitional services, therapeutic foster care, therapeutic foster care for adolescent sexual offenders, human trafficking residential treatment, care coordination, community-based services and supports and Social Services Block Grant Title XX services. All programming provides an array of therapeutic counseling services, including individual, family and/or group therapy that are delivered in the home, community, natural and office settings.

The Centers' services are designed and implemented to support the recovery, health and well-being of persons served; reduce symptoms and build resiliency; restore and/or improve functioning, and to support the integration of persons served in the community. As such, The Centers also provides wraparound support services such as prevention programs for at-risk mothers and their children, parenting education classes, Personal Responsibility Education Life-Skills Program, consultation, referral to housing services and assistance with navigating the judicial system.

In 2018, The Centers provided care to 3,022 families in Arkansas. The majority—2,748—lived in Pulaski County. Children and adults served included priority populations currently defined by DAABHS including those without insurance, the underinsured, ASH-related clients and individuals with severe behavioral illness who are at-risk of being placed in hospitals, jails and emergency rooms. The Centers has a current OBHA certification from DHS within Region 6.

With a long-standing commitment to serving individuals with SMI and children and youth with SED, The Centers and LRCMHC have firsthand experience with the challenges and difficulties facing these individuals and their families. We strive to provide care that yields the greatest outcomes and therefore offer the following evidence-based and professionally recognized practices throughout our programming.

| Evidence-Based Practice | Description |
|---|---|
| Cognitive Behavior Therapy (CBT) | for persons experiencing a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders and severe mental illness. |
| Trauma Focused-Cognitive Behavior Therapy (TF-CBT) | for children and adolescents impacted by trauma and their parents or caregivers |
| Motivational Interviewing | for eliciting behavior change by helping clients to explore and |

| | |
|---|---|
| | resolve ambivalence through a directive, client-centered approach |
| Child Parent Psychotherapy (CPP) | for children 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder |
| Parent-Child Interaction Therapy (PCIT) | for children ages 2 through 7 with disruptive behavior problems |
| Cognitive Behavior Therapy for Psychosis (CBT-p) | for persons with schizophrenia and related disorders |
| Individual Resiliency Training | for initial schizophrenia episode early treatment. |
| Eye Movement Desensitization and Reprocessing (EMDR) | for persons experiencing distress associated with traumatic memories |
| Brainspotting | for persons with emotional/body pain, trauma, dissociation and a variety of other challenging symptoms. |
| Acceptance and Commitment Therapy (ACT) | for persons with a variety of disorders including anxiety, depression and co-occuring substance use disorders |
| Dialectical Behavior Therapy (CBT) | for persons with borderline personality disorder |
| Theraplay | for building and enhancing attachment, self-esteem, trust in other and joyful engagement between child and parent or caregiver |
| S.E.L.F. Psychoeducation | for addressing the fundamental problems surrounding exposure to violence without needing to focus on specific individual events within a group setting |
| Seeking Safety Training | for women with a history of trauma and abuse |
| Manualized Group Treatment | for persons with severe anxiety disorders |
| Illness Management and Recovery | for persons with serious and persistent mental illness |
| Prolonged Exposure Therapy | for persons with Posttraumatic Stress Disorder |
| Cognitive Processing Therapy | for persons with Posttraumatic Stress Disorder |
| Exposure and Response Prevention | for disorders in the anxiety spectrum |

The Centers and/or LRCMHC currently provide the following services in Region 6:

- Crisis Intervention
- Crisis Stabilization
- Psychoeducation
- Mental Health Diagnosis
- Psychological Evaluations
- Pharmacologic Management
- Treatment Planning
- Care Coordination
- Individual and Group Behavioral Health Counseling
- Case Management
- Substance Abuse Services
- Medical Services
- Forensic Evaluations
- Adult Rehab Day
- Aftercare Recovery Support
- Medication Distribution

- Community-Based Service and Supports
- First Episode Psychosis
- Medication Assisted Treatment
- Mobile Crisis
- Peer Support
- Psychiatric Assessment
- SPOE Screening
- Social Services Block Grant Title XX Services
- Supported Employment
- Supported Housing
- Warm Line

The Centers has successfully maintained multiple contracts with the Arkansas Department of Human Services that are similar work to those proposed in the RFQ. These contracts include:

- Comprehensive Residential Treatment
  - Scope of Work- Serves children between the ages of five and eighteen who have not responded to outpatient services. Services provided include individual and family therapy, group therapy, psychiatric evaluation and oversight of all treatment, educational services and treatment focused milieu providing 24-hour care and supervision through trauma-informed trained staff. Treatment is directed by an on-staff child and adolescent psychiatrist. Therapy services are provided by licensed professional staff and education is provided by certified teachers.
  - Project Amount-$600,000.00
- Therapeutic Family Homes Program
  - Scope of Work- Serves children between the ages of three and eighteen who are in the custody of DCFS and are experiencing emotional, behavioral, and adjustment problems associated with family dysfunction and foster care. Services provided include crisis intervention/stabilization; individual, group, family therapy; case management services; medication management; and coordination of services with other providers, including linkage to identified services.
  - Project Amount--$2,376,515.00
- Adolescent Sexual Adjustment Program
  - Scope of Work- Specialized treatment and placement program designed to facilitate the reintegration/orientation of low to medium-risk male adolescent sex offenders back into the community via the use of foster families and staff with specialized training and extensive experience working with the juvenile sexual offender population.
  - Project Amount-$529,257.30
- Respite Care

- Scope of Work- Provides time-limited and temporary relief from the ongoing responsibility of daily care to sustain the foster family, adoptive family, or biological family and maintain the child's placement. The Centers has a contract to provide Respite Care in DCFS Areas V, VI, and VII.
- Project Amount-$212,256.00

- Residential Treatment
  - Scope of Work- Serves children and youth that are in DCFS custody and have no home placement options. When the current managed care entity determines a child no longer qualify for comprehensive residential services, DCFS contracts with The Centers to allow the individual to remain housed in a residential bed and a lower per diem rate to cover only food and housing. The Centers' clinical team delivers OBH services that are medically necessary for the individual.
  - Project Amount-$792,634.00
- Counseling Services
  - Scope of Work- Provided counseling services in the individual's home or in a community-based setting utilizing a family-centered approach; intended to strengthen existing family functioning for families whose children were at risk of an out-of-home placement or had experienced an out-of-home placement and were planning on reunification. The program encouraged families to build upon their existing strengths, to develop capacities to meet their needs and to acquire new skills. Services were provided to individuals that were already involved with DCFS and delivered on a 24 hour a day, 7 day a week basis.
  - Project Amount-$135,000.00

The Centers has been the children's affiliate of Little Rock Community Health Center (LRCMHC) for over 35 years and plans to partner with LRCMHC under the proposed contract to continue providing community-based behavioral health services for adults and children in Region 6 of Arkansas. We provide administrative services for LRCMHC including Human Resources, Dietary and Information Technology (IT). LRCMHC is accredited by CARF through June 30, 2020 in the following programs: Crisis Intervention, Outpatient Treatment, Case Management, Service Coordination and Day Treatment. LRCMHC employs 42 clinical staff including 8 independently licensed clinicians, 10 non-independently licensed clinicians, 1 Advanced Practice Nurse, 4 Medical Doctors, 10 Residents and 9 Qualified Behavioral Health Providers.

Beginning July 1, 2019 in an effort to better manage cost and associate funding LRCMHC will contract with The Centers for Administrative Services including grants management for behavioral health services. Under this arrangement, LRCMHC will provide services with reimbursement flowing to LRCMHC from The Centers who will assume the role of grantee. It is anticipated by this arrangement LRCMHC will concentrate on service delivery within its present location and the clinical policies and procedures as well as other operational policies will be

consolidated with those of The Centers. This includes those listed and described in the narrative including Human Resources, Staff Development and Training, Quality Improvement and Compliance, Client Grievance and Rights.

Reviewing LRCMHC's existing Grants and Contracts, the information falls into three separate but related groupings 1) Contracts and Grants related specifically to Housing and Statewide Information Services, 2) Services contract and grants to either reimburse the provision of services or the cost of the service, and 3) Funding to be reimbursed to other organizations subject to fulfilling requires of the contract. The Housing Grants are direct federal grants to LRCMHC for the provision of rental assistance to individuals with special needs such a diagnosed mental illness or substance abuse and continue in active treatment. All of these grants require that the individual is homeless at point of entry. Some 240 households receive assistance by this funding. HUD also funds two grants to support the statewide Homeless Information System that LRCMHC maintains and complies utilization data from all HUD grantees.

PATH is a SAMHSA initiative in each state with the general purpose of providing an open pathway to needed mental health services for individuals who are homeless and experiencing mental illness. LRCMHC has used this grant to provide extensive outreach in community and to act as the gatekeeper for agencies that work every day with the homeless population. Whether working directly with an individual or an agency the goal is similar - engage individuals in seeking need services to stabilize and access treatment and rehabilitation. LRCMHC uses DHS funded Emergency Solution funding to provide "wrap-around" resources to individual served.

Acute Care is a source of state funding to provide crisis intervention and 24 hour stabilization to indigent individuals in a psychiatric crisis. LRCMHC, from the origin of the program, uses the funds to reimburse local hospital care when the individual is not eligible for other forms reimbursement and therefore might not access needed inpatient intervention. LRCMHC has used funds not expended for inpatient care to ensure access to needed medication or in some cases intensive psychiatric care. Approval of inpatient reimbursement is accomplished by completion of a SPOE direct assessment and based on findings of authorization for hospital reimbursement.

Single Point of Entry is provided by a combination of funding from "Crisis Funds" for SPOE screenings as well as Emergency Services that might occur in a hospital ER or other community setting. LRCMHC's mobile crisis service is provided by these funds.

Block grant funds are used to reimburse cost of First Episode Psychosis services where a reimbursement is not available. These fund have paid for training as well program development to better intervene in cases of a first episode of a psychotic disorder and provide through this intervention prevention/postponement of similar episodes in the future. As is the case with other situations of trauma, a psychiatric crisis requires immediate action with application following assessment of engagement and self-management of this mental illness. LRCMHC sees this program as a foundation for Partial Hospitalization for both the Transitional Age and Young

Adult. As the reimbursement process improves, LRCMHC and The Centers will explore developing a local PHP for these populations as well others.

Forensic funding is noted with a category for both Forensic Outpatient and Forensic Evaluations.

Please note the following grants and contracts that directly pertain to this application and LRCMHC's experience and capacity to perform the work entailed in this application.

| **HUD Grants** | | | | | | |
|---|---|---|---|---|---|---|
| Federal | 14.235 | ARMIS | 6/1/18 - 5/31/2019 | AR0002L6F001609 | Ark. Management Information System | 99,210.00 |
| Federal | 14.231 | ESG | 10/1/2018 - 9/30/19 | 4600038261 | Emergency Shelter Grant | 18,400.00 |
| Federal | 14.235 | HMIS - BOS | 3/1/18 - 2/28/19 | AR0045L6F001603 | HMIS - Balance of State Expansion | 52,221.00 |
| Federal | 14.235 | Outreach | 6/1/18 - 5/31/19 | AR0012L6F001609 | Homeless Outreach | 36,311.00 |
| Federal | 14.238 | S+C #43 | 7/1/18 - 6/30/19 | AR0010L6F001609 | Shelter Plus Care | 1,136,788.00 |
| Federal | 14.238 | S+C #44 | 5/1/18 - 4/30/19 | AR0032L6F001607 | Shelter Plus Care | 980,889.00 |
| Federal | 14.238 | Joseph | 5/1/18 - 4/30/19 | AR0006L6F001609 | Joseph | 415,624.00 |
| Federal | 14.238 | Steps II | 4/1/18 - 3/31/19 | AR0042L6F001604 | Steps II | 153,227.00 |
| Federal | 14.238 | Portage House | 7/1/18 - 6/30/19 | AR0007L6F001710 | Portage House | 38,016.00 |
| **Passthrough from State with Federal Distinction** | | | | | | |
| Federal | 93.667 | Title XX | 7/1/18 - 6/30/19 | 4600040198 | Social Services Block Grant | 86,919.02 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Federal | 93.958 | Block-Adult | 7/1/18 - 6/30/19 | 4600040198 | State Scheduled Payment Block Grant | 219,136.00 |
| Federal | 10.558 | Nutrition | 10/1/18 - 9/30/19 | U0032 | Food and Nutrition Grant | 30,000.00 |
| **State Funded Grants** | | | | | | |
| State | | CASSP | 7/1/18 - 6/30/19 | 4600040198 | The Child and Adolescent Service System Program | 34,290.00 |
| State | | CSP A | 7/1/18 - 6/30/19 | 4600040198 | State Scheduled Payment CSP A | 582,780.00 |
| State | | Per Capita | 7/1/18 - 6/30/19 | 4600040198 | State Scheduled Payment Per Cap | 459,783.00 |
| State | | Forensics | Ongoing by Referral | | State of Arkansas/DHS | 113,500.00 |
| State | | Competency Restoration | Ongoing by Referral | | State of Arkansas/DHS | 6,250.00 |
| State | | PATH | 9/1/18 - 8/31/19 | | State of Arkansas/DHS | 72,777.50 |
| State | | Acute Care | 7/1/18 - 6/30/19 | 4600040198 | State Scheduled Payment Acute Care | 470,632.00 |
| State | | Child Block | 7/1/18 - 6/30/19 | 4600040198 | State Scheduled Payment Child Block | 88,646.00 |

**E. 1. D. Provide any information on the proposed CEO, Medical Director, and Director of Clinical Services and their direct relevant functional experience over the last five (5) years per selected area. For each person provide:**

a. **Evidence of qualification and credentials of the respondent's key personnel.**
b. **Resume of CEO, Medical Director and Director of Clinical Services.**

Melissa Dawson, MPA, is The Centers' President/CEO. Mrs. Dawson has 20 years' of management experience in behavioral health. She was Chief Operating Officer of The Centers

for 13 years before assuming the President/CEO role in 2017. She is a member of the Mental Health Council of Arkansas, has established relationships with key DHS officials and is a member of ACF's Region 6 Human Trafficking Taskforce. Mrs. Dawson plans, coordinates and controls the daily operations of the organization and establishes current and long-range goals, objectives, plans and policies in conjunction with the Board of Directors. She has demonstrated the capacity to successfully manage the adequacy and soundness of The Centers' annual $20 million operating budget and continues to plan and direct all investigations and negotiations pertaining to mergers, collaborations and joint ventures with other community-based providers.

Dr. Zarina Shah, M.D. is the Medical Director for The Centers with over 35 years' experience as a practicing psychiatrist. She has been the Medical Director of The Centers since 1995. Dr. Shah is a member of the American Academy of Child and Adolescent Psychiatry, is chair of The Centers' Medication Management Committee and is a member of The Centers' client records committee, utilization management committee and performance improvement committee. Duties include performing and documenting psychiatric evaluations with mental status exam, diagnosis, prognosis and treatment planning, participating/overseeing the development of master treatment plan and prescribing and managing medications. Services are provided on-site and via telemedicine.

David Kuchinski, LCSW, Chief Clinical Officer for The Centers has twenty years of clinical and management experience nurturing a Recovery milieu that fosters a person-centered treatment continuum for adults with serious and persistent mental illness. Throughout his career, he has maintained positive working relationships with DHS, DBHS, Arkansas Medicaid, Value Options (managed care), Arkansas Mental Health Council and the Arkansas State Hospital. He has extensive experience integrating evidence-based practices into the clinical setting. David Kuchinski will also serve as the Clinical Director for LRCMHC under the proposed contract.

Tom Grunden, MSW, Executive Director of Little Rock Community Mental Health has fifty years' experience in psychiatric program and service management and development. His first experience with what was later the research foundation of the Recovery Model or psychiatric rehabilitation was a short experience at Fountain House in 1968. In first experience as clinical social worker he was given the opportunity to develop an adjunctive work preparation and employment program as a step beyond the state's first partial hospitalization. He served on the board of the state's first nonprofit apartment complex, Hillsboro Place. He later worked in the development of the Helena Center's Hospital based services and partial program at Heritage House. While in Helena he co-wrote the first Law Enforcement Assistance grant to develop regional Juvenile Justice alternatives to the prevailing county judge model of hearing juvenile. These experiences plus other opportunities allow him to develop an appreciation for necessary duality of both person-centered treatment and recovery with a systemic array of resources managed to be locally available and readily accessible at times of need by individual or family.

Prior to graduate school to the current time he remains interested in policy and its importance in the establishment of structure within the field of social welfare that supports fields of medicine and specialties such as psychology and psychiatry.

*Refer to Attachment B for resumes.*

**E. 1. E. Letters of Recommendation**

*Refer to Attachment A for letters of recommendation.*

## E. 2 GENERAL SERVICE DELIVERY REQUIREMENTS

**E.2.A. Describe plan to meet all the requirements listed in RFQ Section 2.1. pertaining to the delivery of services in your region.**

The Centers has adopted a comprehensive, person-centered, No Wrong Door model of comprehensive care to meet the needs of clients regardless of the unique need or funding source. This comprehensive continuum was developed through a network of partnerships with community-based providers that are capable of meeting the full array of needs any individual may present with. We are able to conduct warm handoffs through our No Wrong Door referral agreements with established partner providers. Each partner is committed to ongoing No Wrong Door training and improved referral coordination.

To ensure we meet all requirements, The Centers will:

- Serve as the designated Single Point of Entry (SPOE) for all adults in Region 6 whose destination is ASH as well as the single point of access for acute inpatient psychiatric hospitals for clients without a payor source when these services are medically necessary.
- Utilize funding under the proposed contract as the payor of last resort and assist clients in enrolling in healthcare coverage programs for which they may be eligible.
- Utilize mobile crisis screenings and assessments when individuals present in crises within Region 6.
- Respond to the crisis and offer crisis intervention and stabilization, as well as other services, to prevent hospitalization, further deterioration, and meet behavioral health needs of the client.
- Work with the court systems and ASH to conduct the set of Forensic Evaluations assisting the client in through the legal system. Centers is committed to assist clients with services enabling clients to maintain a level of stability to in order to complete their legal obligations and potentially achieving competency.
- Maintain a local behavioral health and community resource directory to ensure public information and education is widely available. We will carry out a monthly public information campaign including postings on social media (Facebook and Twitter) to educate the local community with information about available services, hours of

operation, clinic contract information and how to access agency programming including crisis services. The campaign will include flyers and advertisements in local news media and distribution of information from our referral source marketer, Tracy Abston, to local referral sources including PCP offices, law enforcement, jails, homeless shelters, civic groups, schools and colleges. This resource directory will be evaluated and modified continuously based on individual needs and feedback to facilitate effective outcomes.

We will be guided by the following principles:

1. Provide community-based care for the identified populations, predominantly those without insurance, the underinsured, and ASH-related clients, and actively work to divert individuals with severe behavioral illness from hospitalization, jail, or the emergency room. We will assume responsibility for treating and helping clients continue to live and function within the community. This coordinated care and treatment will include a broad range of services to meet the individual needs so that adults with serious and persistent mental illness will remain healthy and living in the community of their choice. Such services will include, but not limited to, twenty-four (24) hour emergency services, crisis stabilization, re-entry programs, care coordination, hospital aftercare, drop-in center, peer support groups, supported employment and supported housing.
2. Lead community-based crisis intervention and stabilization. Mobile Crisis services will include completing mobile assessments; stabilizing and depending on the assessed need, referring the client for follow-up community treatment; assisting with and/or paying for a hospital bed day, or assisting with admission and payment for an Acute Crisis Unit bed. For individuals without access to a third-party payor source and who are not a member of a PASSE, services will include assessment, stabilization, and referral.
3. Focus on Recovery-Oriented Treatment. The Centers will continue our trauma-informed model of care by focusing on Recovery-Oriented Treatment. Through collaborative community partnerships, we will build and implement a Person-Centered Treatment Continuum to empower individuals to make informed decision, to exercise control over their long term care needs and to achieve their personal goals and preferences. Our No Wrong Door network will alleviate barriers to individuals receiving services.
4. Provide support to clients placed on the waitlist for admission, being admitted to and discharging from ASH, and the Community-based 911 Status individuals. The Centers is committed to taking full care coordination responsibilities for referred clients with all needs related to ASH placement regardless of payor source or circumstance. The Centers will use our No Wrong Door network to provide the least restrictive setting possible for an individual awaiting ASH placement and for post-discharge placement. The Centers is fully aware of the referral demands placed on ASH and is committed to averting ASH placement when possible. Our Leadership Team is very comfortable working with and expanding services to clients on the ACT 911 court order. David Kuchinski's track

record with supervising clients on ACT 911 is very positive and enabled the same treatment and recovery opportunities as individuals without this order.

**E.2.B. Describe your capabilities to provide appropriate services by telemedicine, and how your telemedicine services will meet state and federal requirements to ensure security of client information remains within HIPPA and other confidentiality-related guidelines.**

The Centers is part of an existing telehealth program that follows the provision of telemedicine services as outlined in the OBHS and ABHSCI manuals and will continue offering telehealth services for clients under the proposed contract. We are a member of the Arkansas e-Link and use Cisco MeetingPlace for clients. Arkansas e-Link is a statewide telemedicine network that provides a secure, HIPPA compatible method to provide telemedicine services in unserved, underserved and economically distressed areas in Arkansas. UAMS CDH provides network management, technical support, and training to sustain and expand the network, while also acting as consortium leader to attain discounted broadband services through the FCC Healthcare Connect Fund for eligible entities. A connection with e-Link is required by the state of Arkansas for an agency to provide Medicaid billable services.

The Centers currently has two Medical Doctors (Psychiatrists) and one APRN on staff providing telemedicine services.

## E.3 SERVICE DELIVERY DUTIES

**E.3.A. Describe how you will develop and provide crisis services for adults, youth and children experiencing psychiatric or behavioral crises and how you will develop and utilize mobile crisis teams within Region where you are proposing to provide services. Describe your plan to meet the requirements in RFQ Section 2.3.2.A including but not limited to:**

**a. Serve the following populations in the delivery of crisis services:**

**i. Mobile Crisis population: Adults, youth, and children experiencing a Psychiatric or Behavioral Crisis without a payor source for medically necessary services.**

**ii. Division of Children and Family Services (DCFS) population: All persons in the custody of the DCFS who are not a member of a PASSE.**

The Centers' current Emergency Services Team provides mobile crisis response, including assessment and stabilization, to children and youth experiencing a psychiatric or behavioral crisis and will adapt to meet the requirements of the proposed contract by expanding these services to adults and through a subcontract with LRCMHC. Our Emergency Services Team is currently prepared to serve any/all individuals without a payer source and any/all persons served in the custody of DCFS that are not members of a PASSE.

As a result of providing decades of mobile crisis services to children and youth in central Arkansas, we have established invaluable relationships with local acute hospitals and a network of providers. These collaborative relationships enable us to facilitate immediate hospitalization for clients in need. Our Medical Director, Chief Clinical Officer and Clinical Supervisors oversee an Emergency Services Team that is trained in trauma-informed care and follows evidence-based crisis assessments and stabilization tools. The Centers continues to work to build a network of partner providers in order to ensure a full continuum of care based on clients' unique needs.

At the same time, The Centers has long standing relationships with key DCFS officials. Very often we are called upon to take DCFS clients on an emergency basis or house clients in the middle of the night. In recent years, we adapted a 20 bed group home to serve DCFS hard to place clients based on a request from DCFS. We are committed to maintaining this working relationship and will continue to expand and adjust programming to meet the needs of DCFS clients who are not a member of a PASSE.

**b. Develop, maintain, and follow all procedures for a Mobile Crisis team of licensed behavioral health professionals to provide Mobile Crisis assessment and stabilization.**

The Centers' existing Chapter 27: Emergency Services and Chapter 50: Physician On-Call Policies outline procedures for mobile crisis services and ensures we have licensed mental health professionals, physicians and nurse practitioners on-call 24-7 to offer face-to-face mobile assessment and stabilization. (*refer to Attachment D for full policies*)

Existing procedures for mobile crisis services include:

- Maintenance of twenty-four (24) hour emergency services for individuals who present with Psychiatric and (or) Behavioral Crises.
- After a request for a crisis assessment, the behavioral health professional shall make phone contact within fifteen (15) minutes.
- The behavioral health professional must provide face-to-face assessment within two (2) hours of the emergency and shall assess the individual's immediate safety needs to determine the seriousness of the person's impairment.
- If agreed upon by both parties and documented, the screening can occur outside the two (2) hour time period, for reasonable cause and the cause is clearly documented.
- If the individual in crisis has a behavioral healthcare provider that they have been working with, The Centers may contact that healthcare provider. However, The Centers shall remain responsible for ensuring a crisis assessment and appropriate crisis services are provided.
- All events and actions taken when responding to a mobile crisis assessment must be thoroughly documented in the EMR and documentation must be completed within twenty-four hours of the initial contact.

**c. Utilize a mobile crisis team prevent the deterioration of a Client's functioning and respond to Psychiatric and/or Behavioral Crises.**

The Centers' Emergency Services/Mobile Crisis Team includes six (6) qualified mental health professionals who provide mental health services primarily in the community setting, including the home. Services provided under mobile crisis include assessment, crisis intervention, supportive counseling, information and referrals, including to community-based mental health providers. Mental health engagement, intervention and follow-up support are also provided to help overcome resistance to treatment. LRCMHC has a team of 4 qualified mental health professionals providing these mobile crisis services to adults.

For clients age 18 or older who are assessed during a behavioral health crisis and met the criteria for crisis stabilization admission, we will respond by making a referral to the regional mental health crisis unit, the Pulaski County Crisis Stabilization Center (CSU). CSU would be the least restrictive setting and avert acute hospitalization. Criteria for admission includes age 18 or older, experiencing a behavioral health or substance abuse crisis, willing to accept treatment, not actively dangerous/violent and can physically care for themselves. Both The Centers and LRCMHC have an established reciprocal referral relationship with CSU and will provide care coordination at the request of the individual and facilitate referrals to outpatient mental health services after the individual's stay. Upon discharge from CSU, the individual would be eligible and plugged into our comprehensive continuum of care including but not limited to Drop-In Center services, supported housing, supported employment, outpatient counseling and substance abuse services.

**d. Develop and implement policies and procedures for the management of behavioral health crises for children, youth, and adults. You may describe your existing policies and procedures, if applicable.**

The Centers utilizes a progressive set of best practices and procedures for the management of behavioral health crises. Staff introduce and guide individuals through the Stages of Change Continuum and provide engagement interventions such as Motivational Interviewing to assist clients in finding their own motivation for change. Following this Power of Choice Model empowers clients to make good choices and practice effective coping strategies.

We have adopted Conscious Discipline in our residential and day treatment classrooms to assist clients in practicing coping skills in the education setting. Equipped with coping skills, clients are then able to more effectively transition to their home classroom, especially if their school practices Conscious Discipline. Qualified Behavioral Health Professionals (QBHP) assist clients with this critical transition by practicing the preferred coping skills in their home classroom.

The Centers will follow our existing policies and procedures for the management of behavioral health crises for children, youth and adults. The policies and procedures include Chapter 17:

Behavior Management and Treatment Intervention and Chapter 16: Emergency Safety Interventions (*refer to Attachment D for full policies*).

These policies and procedures are reviewed and approved either annually, every two years or every three years by The Centers' Board of Directors.

**e. Develop and utilize a screening assessment tool, including an evidenced-based crisis assessment tool, to measure immediate and potential safety needs and protocols for using the screening assessment.**

Our Emergency Services Team has adopted and implemented the evidence-based SAFE-T standardized crisis assessment tool to measure immediate and potential safety needs during a crisis. This evaluation and triage plan assists us with making clinically indicated recommendations based on medical necessity. The five-step plan involves 1) identifying risk factor 2) identifying protective factors 3) conducting a suicide inquiry 4) determining risk level and interventions and 5) documenting a treatment plan. The immediate and potential safety needs of clients are measured using age, gender and culturally appropriate defined criteria.

The Centers makes every effort to keep individuals in the least restrictive placement possible. As part of our ongoing performance improvement process, we analyze each hospitalization and averted hospitalization to identify early intervention strategies and relapse prevention techniques to minimize hospitalizations. If hospitalization is needed, all steps are taken and/or contacts made to locate acute placement are documented as well as contacts made to the individual's behavioral health treatment team members to help resolve the crisis. Documentation also includes how the team worked with the caregiver or support network to de-escalate the crisis and problem solve to recommend a course of action.

Protocols are established for using SAFE-T that would adequately triage planning and care for all individuals in Region 6. If for any reason the individual needing acute placement is not placed immediately, The Centers will continue to document attempts for placement until appropriate placement is secure and the individual is placed.

Crisis intervention and stabilization services are provided in a community setting to any screened individual until placement in an acute setting, or the individual is deemed stable by a medical or behavioral health professional and stabilization is clearly documented by one (1) or more of those professionals.

**f. Provide and staff a Warm Line or an outpatient Drop-In (Walk-in) clinic available to Clients in need of lower threshold intervention, or crisis services, on the evenings, weekends, and holidays.**

The Centers will provide a Warm Line to clients in need of lower threshold interventions on the evenings, weekends and holidays by adding an additional line to our existing emergency

services/crisis hotline (501-666-8686). The Warm Line will be staffed and manned by a qualified behavioral health provider (QBHP) with lived experience, preferable a certified Peer Support Specialist, trained in evidence-based crisis practices. The QBHP will offer support and assistance, continue to assess the needs of our community and use the information to offer pertinent educational resources and/or continue to build a comprehensive support network for individuals. When appropriate, callers will be connected to crisis assessment services by one of our on-call Emergency Services Team member.

We will be able to accommodate a Drop-In Center as a resource for clients and an additional support network within our existing facilities at 6601 West 12th Street, Little Rock Arkansas 72204. This would be a consumer initiative and offer members opportunities for friendship, employment, housing, education and access to behavioral health services through a caring and safe environment. The Centers has both English and Spanish speaking clinicians that offer "Same Day Access" which allows us to provide same day intakes and assessments, start outpatient services immediately and keep individuals and families engaged in treatment. The Drop-In Center will be available to clients in crisis during evenings, weekends and holidays.

**g. Utilize mobile crisis teams to triage individuals into the least restrictive services.**

Providing care in the least restrictive setting drives The Centers' treatment methodolgy. Our well-designed crisis response system uses qualified mobile crisis teams to triage individuals in the community and deter individuals from utilizing unnecessary higher levels of care. Our pre-screening assessments act as gatekeepers for inpatient hospitalization and connect individuals with community-based programs and services.

Mobile crisis team services include crisis stabilization; access to immediate outpatient treatment by behavioral health professionals; and referrals to substance abuse detoxification, the Pulaski County Acute Crisis Unit, or acute psychiatric hospitalization. All intervention services are documented in the client's EMR.

Our community-based crisis interventions deter hospitalizations by keeping individuals out of emergency rooms when it is avoidable and pairing them with necessary support services. We will connect first-time users to appropriate services and improve community relations by providing reassurance that the individual's needs are met during a mental health crisis.

**h. Develop and utilize crisis stabilization plans for clients diverted from acute hospitalization including documentation of all follow-up post crisis stabilization.**

In the case of acute hospital diversion, The Centers will follow existing procedures of our crisis stabilization plan The crisis stabilization plan clearly documents scheduled appointments and connection with outside resources and natural supports, follow-up procedures for the individual as well as for the treatment team, and diversion alternatives that The Centers plans to make available including resources in the community to which the family can be connected. The

individual's suggestions are taken into account in the development of the plan to help the individual avoid harming self or others or feel anxious or afraid until an intervention can begin or be continued.

For the DCFS population specifically, The Centers makes every reasonable effort to divert from acute hospitalization. If diversion can occur, a written safety plan is implemented and shared with applicable individuals (e.g. the child when age appropriate, DCFS worker/supervisor, and adult in the child's current placement). The safety plan assesses for the client's protective factors, identifies triggers, and allows the client to provide input on effective coping strategies including what strategies have worked for them in the past. The plan also ensures the team and individual remain safe and that individualized interventions and directions are prescribed. Qualified behavioral health professionals complete a face-to-face follow-up within twenty-four (24) to forty-eight (48) hours of the initial crisis.

For a re-occurring crisis, The Centers' Emergency Services Team re-evaluates the recommendations of any previous crisis/safety plan and uses a Wraparound approach to placing the individual and providing additional treatment and supportive services. Follow-up post crisis stabilization documentation occurs through a record of services in the individual's EMR.

**i. Provide or make a referral for any clinically necessary, alternative psychiatric treatment following a Mobile Crisis assessment.**

Following a mobile crisis assessment, The Centers will provide any clinically necessary alternative psychiatric treatment or make a referral to the individual's current behavioral healthcare provider or care coordinator. The Centers or LRCMHC will act as the SPOE for individuals who present in Region 6 who are being considered, voluntarily or involuntarily, for referral to the inpatient programs of the ASH.

The Centers will complete, upon request, any paperwork or court appearances related to involuntary commitments.

**j. Coordinate with community partners to ensure comprehensive aftercare and provide discharge planning for all persons leaving an acute setting.**

The Centers will take primary responsibility for ensuring comprehensive aftercare and discharge planning for all persons leaving an acute setting, as notified by the hospital. Discharge planning will include a scheduled appointment to take place no later than seven (7) days after discharge from the hospital, making every effort ensure clients are adherent with medications and attend follow up medical appointments, minimize re-hospitalization within 30 days. When we are unable to manage the plan, we will call upon our wide network of established community partners. Coordination with these community partners will ensure comprehensive aftercare planning for individuals with a psychiatric or behavioral health crisis who are frequently jailed or in acute crises.

**k. Administer Acute Care Funds for psychiatric hospitalization for adult Clients experiencing a Psychiatric or Behavioral Crisis.**

Our partner in the proposed contract, Little Rock Community Mental Health Center, has extensive experience executing and administering Acute Care Funds (ACF) for psychiatric hospitalization for adult clients experiencing a Psychiatric or Behavioral Crisis and we will refer to their expertise in administering these funds. ACFs will be utilized as a payor of last resort and made only available for use with persons aged eighteen (18) and older.

If an adult is not a member of a PASSE and has no payor source to cover hospitalization, The Centers will use ACF to pay for the hospitalization. This will include individuals served by other agencies who are without funds to pay for hospitalization. The Centers will take financial responsibility for admission and continued stays that are determined to be clinically necessary by the admitting facility. A licensed mental health professional will attend staffing at the inpatient facility to determine if extended days are necessary or if the client is appropriate to transition to outpatient services. Assistance with obtaining appropriate insurance cover for the individual will take place immediately upon discharge from the inpatient setting.

As an alternative diversion from psychiatric hospitalization, The Centers will use ACF to pay for the provision of services in a DHS certified Acute Crisis Unit. For the purpose of expenditure of ACF for treatment in a certified Acute Crisis Unit/Crisis Stabilization Unit, The Centers will serve a client living in a family with income up to two hundred percent (200%) of the federal poverty level and is not eligible for Medicaid.

**Vendors are encouraged, but not required to provide Therapeutic Communities (TC) or Acute Crisis Unit (ACU), or sub-contract with one. If you propose to provide an ACU or TC, describe your plans to implement and staff the proposed ACU, including the date when your ACU will be able to serve Clients. Describe your plan to provide services to clients at your ACU. If you plan to sub-contract, describe your plans on implementing appropriate agreements, projected costs, and accessibility.**

The Centers recognizes a significant need for Therapeutic Communities (TC) in the central Arkansas area. A sizeable population of current TC residents long to return to their home communities in central Arkansas but have limited supported housing and support networks to make a successful transition.

Immediately following the awarding of this contract, The Centers will actively pursue certification for Therapeutic Communities. David Kuchinski, Chief Clinical Officer, opened several TC sites across Arkansas when this service was made available via OBHS. He developed a working relationship with DPSQA certification to pass site inspections, develop pertinent CAPS and implement TC for psychosis best practices. Mr. Kuchinski also has extensive experience observing qualitative outcomes from Peer Support interventions.

With The Centers' addition of TC, individuals would be able to step down from ASH and acute hospitals into a living environment close to their home. The Centers would also develop a full continuum of care for adults to ensure an effective transition from TC to a supportive housing situation with a warm handoff to Tier 2 outpatient therapy and QBHP services. For clients residing in TC residence, The Centers will offer educational and supported employment opportunities to enable clients to reconnect with their community and establish a recovery plan to develop and sustain functional improvements that increase autonomy and functionality.

Our proposed TC will provide a person-centered approach to recovery that is staffed by qualified behavioral health professionals with lived experience to foster enhanced rapport, refine recovery plans and enhance interventions that yield qualitative, measureable improvements in clients to move them through the continuum and graduate from TC quicker. With David Kuchinski's experience in staffing Therapeutic Communities in the recent past, he is aware of available staff with valuable experience in the central Arkansas area that could build an immediately effective team. The Centers also has many existing staff with residential and crisis experience that could transfer to the TC team. Our proposed TC will be able to serve clients nine months after acquiring the contract.

Before our TC is established, we will send referrals for Therapeutic Communities services for adult clients with a serious mental illness to Birch Tree Communities, Inc. (*refer to Attachment C for MOU*).

The Centers will subcontract with Pulaski County Crisis Stabilization Unit (CSU) for acute crisis services and hospital diversion. If Pulaski County has limited capacity or cannot serve all referrals, The Centers will assess the feasibility in opening an Acute Crisis Unit, using David Kuchinski's experience having been the first to open this unit in Arkansas. The Centers' Acute Crisis Unit could be utilized as an additional ASH diversion and serve the central Arkansas region regardless of civil commitment or 911 status.

**E.3.B. Describe how your company will provide services to ASH patients, potential patients, and former patients within the Region you are proposing to provide services and describe your plan to meet the requirements in RFQ Section 2.3.2.B including but not limited to:**

**a. Serve the following population in the delivery of services pertaining to ASH within the Vendor's Region:**

> **i. Adults, youth, and children residing within the Vendor's respective Region, who are awaiting an ASH bed, Clients referred by ASH currently receiving services at ASH who were residing in Region at time of admission and preparing for discharge to return to Region, or Client referred by ASH who have been discharged from behavioral health treatment services at ASH, including those with Community-based 911 Status.**

The Centers seeks to improve the quality of life for all Arkansans by providing a comprehensive, recovery-based and consumer-driven behavioral health system of care utilizing evidence-based and promising practices, including trauma-informed care, across all areas. We value the strengths and assets of consumers and their families and recognize these components as an integral part of treatment. Under the proposed contract, we will provide services to adults, youth and children in Region 6 who are awaiting an ASH bed, clients preparing for discharge from ASH and clients who have been discharged from behavioral health services at ASH, including those with community-based 911 status. We will assist with care coordination for these clients, both adults and children, and provide step down services as needed from ASH.

We will refer to the expertise of our partner, LRCMHC, as they have extensive experience coordinating services for existing, potential and former ASH patients, including those with Community-based 911 status. Both The Centers and LRCMHC have existing collaborative relationships with staff at ASH and are committed to improving care for individuals under the proposed contract by seamlessly plugging individuals into needed care and expediting care coordination services.

**b. Serve as the Single Point of Entry (SPOE) for ASH:**

**i. Ensure an SPOE screening occurs within two (2) hours of the initial request by a licensed behavioral health professional.**

The Centers' existing Emergency Services Team is made up of five licensed mental health professionals and a medical doctor who are trained with documented competency to complete the ASH SPOE screenings for assessment and placement purposes for individuals experiencing serious psychiatric emergencies in Region 6. LRCMHC also has licensed mental health professionals conducting SPOE screenings through request from the courts and through their crisis hotline. In January 2019, LRCMHC facilitated 51 SPOE admissions.

The Centers and LRCMHC will act as the SPOE for individuals in Region 6 who are being considered, voluntarily or involuntarily, for the ASH inpatient program. These screenings will be used to determine if the individual meets the criteria for admission to inpatient programs of the State Mental Health System, to determine if appropriate alternatives to inpatient treatment are clinically appropriate and available and to arrange for the provision of alternative outpatient services if inpatient or crisis residential services are not recommended.

Our Emergency Services Team is on-call 24/7, ensuring the SPOE screenings will occur within two (2) hours of the initial request and quickly assess whether inpatient services as ASH are medically necessary.

**ii. Ensure the SPOE assessment is completed completely and accurately.**

Licensed behavioral health professionals will use the DHS certified SPOE assessment form which includes an evidence-based screening tool. If the individual is screened in an inpatient/medical facility or emergency room, the following will be included in the assessment:

- Completed SPOE/Crisis Intervention Form noting acute psychiatric symptoms dated within the last seventy-two (72) hours
- Hospital Face sheet with complete demographic/financial information
- All Nurse and Physician progress notes
- All Physician Orders
- Medication Administration Records (MAR)
- Emergency Room Admission Data (*if applicable*)
- A signed statement by the attending physician stating that the client is medically cleared/stable for discharge, not transfer, from the inpatient medical facility
- All Lab/EKG reports
- Medical/Psychiatric Consults
- History and Physical
- Psychiatric Evaluation (*if applicable*)
- Vital Sign and Height/Weight Record
- Court Order/Jail Hold Order (*if applicable*)
- Guardianship Papers (*if applicable*)

If the SPOE screening is completed in a clinic, the following information will be included:

- Completed SPOE/Crisis Intervention Form noting acute psychiatric symptoms dated within the last seventy-two (72) hours and the client's physical location for discharge after stabilization
- Demographic/Financial Information
- Emergency contact information
- Where in Region 6 the client be placed when stabilized
- Court Order/Jail Hold Order (both if jail hold)
- For reconsiderations: updated progress notes, physician orders, MAR and functional status reports.
- The Centers letter of authorization

The Centers' Chief Clinical Officer will review, sign off and send a letter as proof of authorization of the SPOE assessment, assuring that it was completed completely and accurately.

**c. Serve Clients on the ASH waiting list:**

**i. Describe what services you will make available to provide support and stabilization to those awaiting admission.**

To provide support and stabilization to any individual awaiting admission to ASH, The Centers will provide care coordination, including pursuing insurance enrollment for the individual. The Centers will also provide any appropriate and medically necessary services available under the current OBHS and ABHSCI manuals to support stabilization for those awaiting admission to ASH or for those individuals discharging from ASH who are uninsured or underinsured. Services will include, but not limited to, peer support, outpatient counseling, and referrals to partial hospitalization, day treatment, acute crisis, Therapeutic Communities and substance abuse services. If appropriate, the client may access The Centers' Drop-In Center or be referred to Drop-In Model services of another community-based provider.

When necessary, The Centers will secure acute hospitalization with another provider if a bed is not available at ASH. This includes documenting all efforts toward placement in the individual's EMR.

**d. Serve Client actively admitted to ASH as they prepare for discharge:**

**i. Provision of Care Coordination and other services which may assist with discharge and continuity of care.**

When ASH notifies The Centers about a client's upcoming discharge, The Centers will take responsibility for their discharge planning and transition, assess placement options and plug them into The Centers or another community provider's continuum of care based on their needs.

Discharge planning efforts will include services to ensure that therapy, medication management and coordination of a primary care physician are in place. Care coordination will be provided by QBHPs to assist clients in gaining timely access to appropriate services and ensure communication between agencies, providers, and other individuals necessary to implement the goals identified in the treatment plan. To ensure continuity of care, services will also include facilitating linkages between providers of community-based resources, service referrals to ensure necessary behavioral health interventions including medication management are in place, ensuring the individual is receiving an appropriate level of care and assistance in obtaining appropriate Medicaid, Medicare, private insurance, Veterans Administration benefits, or other third-party coverage. For all clients discharging from ASH, the first appointment will be a scheduled appointment no later than seven (7) days after discharge. The Centers will verify that appropriate insurance enrollment has been initiated prior to discharge. If applicable, housing and transportation will be arranged. LRCMHC has existing HUD grant funding in place for

housing and transportation assistance and we would connect individuals in need of this service to LRCMHC.

The Centers will remain in regular communication with designated ASH staff with regards to ASH's recommended discharge planning needs, as well each client's needs.

**e. Serve all ASH discharges referred by ASH to the Vendor regardless of the payor source.**

The Centers will serve all ASH discharges referred by ASH regardless of the payor source, including those without insurance or who are not a member of a PASSE, or when requested by DHS. Care coordination, including assisting the individual in obtaining appropriate insurance coverage, will be provided.

For all clients discharging from ASH, the first appointment will be a scheduled appointment no later than seven (7) days after discharge. All medically necessary services under the current OBHS and ABHSCI manuals will be made available to assist and support with stabilization for those individuals who are uninsured or underinsured.

**f. Provide services to Community-based 911 Status Clients regardless of the payor source.**

David Kuchinski successfully managed the care of 125 911 Status clients for over 15 years at Birch Tree Communities, Inc. LRCMHC also has extensive experience providing services to community-based 911 Status clients. Under David Kuchinski's clinical leadership, both The Centers and LRCMHC have the capacity to manage referrals and provide services as prescribed to community-based 911 clients under the proposed contract.

The Centers will provide necessary treatment for 911 status clients who are discharged on a conditional release order regardless of payor source, who are not a member of a PASSE, or upon DHS request. As individuals on 911 statuses are required to comply with medications, treatment and therapy, substance abuse treatment, and drug testing as prescribed, The Centers will coordinate with the state to ensure these clients receive the need treatment within the community. Services may be provided within The Centers continuum of care or through referrals made to other community-based providers. For clients discharging from ASH, the first appointment will be a scheduled appointment no later than seven (7) days after discharge.

For clients currently on conditional release that have no insurance or insurance other than Medicaid, care coordination, including assistance pursing appropriate insurance coverage enrollment, will be provided. The first appointment for clients discharging from ASH will be scheduled no later than (7) days after discharge. All medically necessary services under the current OBHS and ABHSCI manuals will also be made available to assist and support with stabilization for those individuals.

**E.3.C. Describe how you will provide Forensic Evaluations to Clients within the Region you are proposing to provide services and describe your plan to meet the requirements in RFQ Section 2.3.2.C including but limited to:**

**a. Provide ACT 327, ACT 328, and ACT 310 Forensic Evaluations to the RFQ-defined population according to Arkansas Code Annotated (ACA) §§ 5-2-327 and Arkansas Code Annotated (ACA) §§ 5-2-328.**

When a judge orders an ACT 327 or ACT 328 forensic evaluation to determine if there are concerns regarding the competency, responsibility, and (or) capacity of an individual to proceed within the criminal justice system, The Centers will provide a Qualified Psychologist through a subcontract with LRCMHC to perform the initial ACT 327 or ACT 328 evaluation, or subsequent ACT 310 Evaluations, as defined in Arkansas Code Annotated (ACA) §§ 5-2-301 through 5-2-329.

LRCMHC has four (4) Qualified Psychologists on staff conducting Forensic Evaluations: Dr. Hugo Morais and Dr. Elisa Smith conduct Forensic Evaluations in the jail setting and Dr. Rachael Fazio and Dr. Ed Stafford conduct Forensic Evaluations in both the outpatient clinic and jail setting. On average, LRCMHC processes 30 forensic evaluations each month.

LRCMHC will notify the Forensic Services Program Director of the scheduled date of any ACT 327, ACT 328, or ACT 310 evaluation within five (5) business days of the notification from ASH. LRCMHC will ensure that all four (4) Qualified Psychologists attend annual updates of the forensic certification course approved by DHS and appear in court and give testimony as required by the court or upon request by DHS and (or) DAABHS.

**b. Provide court-ordered Forensic Evaluations within the timeframes listed in the RFQ.**

Upon completion, all ACT 327, ACT 328, or ACT 310 Forensic Evaluations will be filed by LRCMHC with the courts and made available to the DAABHS Forensic Program Service Director within the mandated timeframe.

**c. Provide Qualified Psychiatrists and/or Qualified Psychologist to perform the ACT 327, ACT 328, and ACT 310 Forensic Evaluations.**

The Centers will provide four Qualified Psychologists to perform the ACT 327, ACT 328, and ACT 310 Forensic Evaluations through a subcontract with LRCMHC. *Refer to Section E.3. C. a. for details.*

**d. Refer Clients not fit to proceed with the criminal justice/legal process to the Forensic Outpatient Restoration Program.**

For clients who are not fit to proceed with the criminal justice/legal process, The Centers will provide Forensic Outpatient Restoration Program (FORP) services. The Centers' has a team of

mental health professionals trained in providing FORP to help these individuals regain competency and will continue providing these services under the proposed contract. Currently, our caseloads include five (5) active FORP clients. LRCMHC has provided FORP services for three (3) years and averages a caseload of 10 FORP clients each month.

FORP services will be provided to individuals residing in the county jail or in the community. FORP services will ensure that all necessary agencies and programs are involved and made available for clients needing restoration services, such as medication management and therapy services. All data related to services for forensic evaluations population will be submitted in a timely manner upon request to DHS. When clinically indicated a FORP client will be referred for outpatient services to ensure all client needs are addressed. Medication management and pertinent case management may be provided as well.

If a client's behavioral health condition deteriorates and The Centers deems necessary that this individual requires an inpatient setting, or a client is found by The Centers be non-restorable after a period of six (6) months, the individual will be referred to ASH for discretionary consideration of admission.

If the client is determined to be restored by The Centers after FORP services are rendered, one of LRCMHC's four (4) Qualified Psychologists will perform an ACT 310 evaluation to confirm restoration and provide the court with the evaluation results.

**E.3.D. Describe how your company will administer the Forensic Outpatient Restoration Program and describe your plan to meet the requirements in RFQ Section 2.3.2.D including but not limited to:**

**a. Serve the RFQ-defined population according to Arkansas Code Annotated (ACA) §§ 5-2-327 and Arkansas Code Annotated (ACA) §§ 5-2-328 in the delivery of FORP services.**

The Centers and LRCMHC will provide FORP services to individuals who have been deemed unfit to proceed with the criminal justice or legal process according to according to Arkansas Code Annotated (ACA) §§ 5-2-327 and Arkansas Code Annotated (ACA) §§ 5-2-328. We are committed to providing the full array of services available under FORP to increase success of restoration services and meet individual's full mental health needs. David Kuchinski has years of experience assessing and treating individuals undergoing the evaluation process and will supervise FORP services. FORP provides stabilizing support and services to assist clients in successfully participating in the evaluations in the community, minimizing ASH placement when possible. The Centers will recommend individuals with serious mental illness be placed in TC for stabilization and achieve restoration/fitness to proceed if they are too acute to restore in their home. This would divert unnecessary placement in ASH.

**b. Provide all educational, clinical, and medically necessary behavioral health services to individuals awaiting a trial or hearing.**

The Centers and LRCMHC have qualified mental health professionals on staff trained in the Forensic Outpatient Restoration Program and we will continue to provide this service under the proposed contract. The most current DHS-approved curricula will be followed and The Centers will ensure FORP clients referred from ASH will have their first appointment within seven (7) days of the referral. If the client fails to arrive for any appointment, The Centers will notify ASH by the next business day following the day of the missed appointment.

The following educational, clinical and behavioral health services will be provided, as medically necessary, to individuals in FORP who are awaiting a trail or hearing:

- Care Coordination including but not limited to, court appearances, facilitating linkages between court and jail personnel, transporting clients, and service referrals
- Drug Screen
- Marital/Family Behavioral Health Counseling
- Group Behavioral Health Counseling
- Interpreter Services, *with prior approval from DHS*
- Purchase of medically necessary psychotropic medication
- Pharmacological Management
- Mileage Reimbursement
- Mental Health Diagnosis
- Psychiatric Assessment
- Psychological Evaluation
- Treatment Planning

We are committed to providing FORP services but also to providing quality wraparound services as needed upon completion of FORP, including outpatient counseling services and case management. Providing wraparound services for FORP clients will ensure individuals remain connected to a mental health continuum of care and received individualized care, tailored to their unique needs.

**c. Have qualified staff in place to provide didactic competency services.**

The Centers has three (3) qualified mental health professionals in place to provide didactic competency services and will ensure any new hires providing didactic competency services under the contract attend the established training sessions provided by ASH involving the restoration curriculum.

**d. Document progress notes or reports, with the DAABHS specified criteria, and send to designated DHS staff within DAABHS required timelines.**

Progress notes or reports, with the DAABHS specified criteria, will be documented in the individual's EMR and sent to designated DHS staff within DAABHS required timelines and via method of transmission required by DAABHS or ASH.

The Centers' Chapter 69: Documentation of Service Provision Policy provides general guidelines for the documentation of services provided to clients by The Centers staff and will adhere to these procedures for documentation of all services under the proposed contract (*refer to Attachment D for full policy).*

**e. Provide Individual Outpatient Restoration according to the RFQ requirements.**

Individual Outpatient Restoration services will be provided for clients in jail or in the community and will follow the prepared educational curriculum. Clients being seen for FORP educational purposes involving restoration will be seen by a licensed mental health professional (if psychotherapy is warranted) or by a certified qualified behavioral health provider (QBHP).

All individual outpatient restoration services will consist of structured sessions that work toward achieving mutually defined goals as documented within the Individual Treatment Plan and (or) restoration curriculum.

**f. Provide ACT 310 Forensic Re-Evaluations for Clients to have been restored to competency.**

Upon determination by the qualified mental health professional or certified QBHP that a client has been restored to competency, The Centers will contact the DAABHS Forensic Services Program Director and request for an ACT 310 forensic re-evaluation. At the minimum, monthly face-to-face contact with the FORP client will occur between the time the individual has been restored and while awaiting the 310 Evaluation.

**g. Determine need for and request ASH inpatient admission for any Client you cannot restore as an outpatient Client.**

The Centers will request ASH inpatient admission for any client that cannot be restored as an outpatient client within six (6) months of the original court orders file date. Such requests will be submit by The Centers to the DAABHS Forensic Services Program Director for discretionary consideration of inpatient admission at ASH.

To assist with and support stabilization for clients awaiting admission, The Centers will make Drop-In Model services available (if appropriate) and provide care coordination and medically necessary services under the current OBHS and ABHSCI manuals. No less than monthly contact will occur between the client and The Centers during the waiting period for admission to ASH.

**h. Schedule a Psychiatric Assessment for any referred defendant for whom there has been no psychiatric evaluation within the past six (6) months.**

If ASH/DAABHS refers a defendant for whom there has been no psychiatric evaluation within the past six (6) months, The Centers will schedule a Psychiatric Assessment (PA) as part of the restoration curriculum. Upon the completion of a PA, and if found necessary, The Centers will

provide all medically necessary behavioral health services to the client throughout the course of the client's participation in the FORP.

**E.3.E. Describe how your company will provide services to Non-Medicaid individuals who meet criteria for Serious Mental Illness within the Region you are proposing to provide services and shall describe your plan to meet the requirements in RFQ Section 2.3.2.E including but not limited to:**

**a. Provide Care Coordination to non-Medicaid clients including insurance enrollment.**

The Centers currently provides care coordination, including insurance enrollment, for non-Medicaid clients under our Therapeutic Counseling contract with DHS. We will continue facilitating this and other care coordination services including Drop-In Model services to non-Medicaid individuals with the need for necessary services under the proposed contract.

**b. Provide medically-necessary services described in the current Outpatient Behavioral Health Services Manual and the Adult Behavioral Health Services for Community Independence Manual to non-Medicaid Clients.**

For services not available through the client's insurance carrier, The Centers will provide medically necessary services available under the current OBHS and ABHSCI manuals to assist and support with stabilization. This is specific to services not available through the individual's insurance carrier, not the number of services an insurance carrier will cover. The Centers will contact the insurance carrier to request additional services that are medically necessary. Contract funds will only be used when the insurance carrier has denied extension of benefits on the requested services. All requests for, and provision of services, will be documented in the client's medical record.

**c. Provide Drop-in Model or Club House Model services to non-Medicaid Clients.**

Our current treatment teams provide care coordination services and would extend those services to non-Medicaid clients under the proposed contract. The Centers is aware of the documented effectiveness of Drop-In Centers for people with severe, persistent mental illness. Studies of Drop-In Centers have found that members who attend have a decrease in suicide rate, substance abuse, and crisis unit admissions. Members also show an increase in social contacts, quality of life, problem solving abilities, and the ability to carry out the activities of daily living.

We will therefore implement this service using SAMSHA's evidence-based guidelines for the practice. This includes staffing the Drop-In Center with individuals with lived experience to empower the effectiveness of peer support. Peer support specialists will provide emotional support to members and conduct a variety of activities including self-help groups, education groups, self-expression, functional coaching, problem solving and access to community resource guides. Psychoeducation will also be provided to disseminate pertinent information regarding

mental illness, substance abuse, and tobacco cessation, and teach problem-solving, communication, and coping skills to support recovery. Psychoeducation services will be congruent with the age and abilities of the individual, client-centered, and strength-based; with emphasis on needs as identified by the individual and provided with cultural competence. As the Drop-In Center will be co-located with The Centers' other continuum of programming, crisis stabilization will also be available to members at any time.

The focus of the Drop-In Center will be socialization, advocacy, and self-help for each individual on their personal journey to recovery. Through peer support, members will gain self-esteem, learn to advocate for themselves, and become empowered to strive for recovery.

Our existing infrastructure at 6505 West 12th Street in Little Rock can accommodate the addition of a Drop-In Center. Co-locating the Drop-In Center with The Centers' existing continuum of programming will benefit members and ensure crisis stabilization will be available to individuals who may be in need of this service.

**E.3.F. Describe how your company will provide services for the First Episode of Psychosis (FEP) within the Region and describe your plan to meet the requirements in RFQ Section 2.3.2.F including but not limited to:**

**a. Make FEP services available to the individuals between the ages of fifteen (15) and thirty-four (34) who are experiencing FEP who are without a payor source, or have insurance benefits that will not reimburse for FEP services.**

As The Centers recognizes that early identification, intervention and treatment of psychosis increases the chance of successful recovery and improved functionality, our FEP services will include recovery-oriented, person-centered and relationship-based treatment. FEP services will be provided by a trained clinical team to individuals between the ages of fifteen (15) and thirty-four (34) who are experiencing FEP who are without a payor source, or have insurance benefits that will not reimburse for FEP services. Our agency has already implemented evidence-based principles and training materials to provide treatment to those with early SMI including but not limited to psychosis and will follow a collaborative, recovery-oriented approach to FEP under the proposed contract that involves clients, treatment team members and when appropriate family members as active participants. LRCMHC has two (2) licensed mental health professionals providing FEP services with an average of 4 clients on their caseload each month.

**b. Conduct education and outreach in the community to enhance awareness of symptoms and treatment options for FEP.**

The Centers has the capacity to systematically dissemination information about FEP and facilitate a successful referral and enrollment process. Community outreach for FEP will be conducted by Tracy Abston, Referral Source Marketer for The Centers and community education for FEP with be facilitated by Mark Bryant, LPE, Director of Training at The Centers.

Prior to the initiation of outreach and recruitment activities, Mark Bryant will develop materials that help communicate information about FEP services and serve as entry points for potential clients, family members and other service providers to learn about and contact program staff. Written literature will include brochures and flyers that specifically target 1) consumers and family members and 2) other providers. Materials written for consumer and family members will speak to the overall goals of the program and briefly describe specific program activities using person-centered and non-diagnostic terminology. Materials targeting other providers will highlight the need for early intervention, using clinical terminology to describe consumers. Electronic versions that can be shared via email will also be made available.

Coordinated specialty care for FEP will include twice monthly community education and awareness events throughout Region 6 that enhance awareness of symptoms and treatment options for FEP. Mark Bryant will facilitate these events as he is a Licensed Psychological Examiner with extensive experience conducting presentations to various audiences including physicians, mental health professionals, school counselors and law enforcement. Outreach activities will focus on stigma reduction, early identification and linkage of services. All outreach activities and referrals will be tracked by Mark Bryant through the use of an Excel spreadsheet. Elements in the outreach tracking system will include the organization/agency name; specific units/department; names of particular agency contacts and relevant contract information, and tracking outreach (date/name/type of activity and plans for follow up).

Ongoing public education will be carried out through written literature distributed by Tracy Abston to the following stakeholders in Region 6 at least every six (6) months: high-school counselors/teachers, college counseling centers, primary care physician's offices, law enforcement, juvenile court and juvenile probation officers, homeless shelters, jails and emergency departments. Tracy Abston will be trained in the core components of the FEP program prior to distribution of all materials.

**c. Implement FEP services using an evidence-based model that includes elements described in RFQ Section 2.3.2.F.4.**

Implementation of our FEP services will be based on coordinated specialty care that emphasizes outreach, low-dosage medications, case management, family psychoeducation, supported employment and supported education. These services will be provided by dedicated members of our treatment team to facilitate individual's experiencing FEP success in work and school.

Clinical supervision including reviewing incoming referrals and addressing any barriers encountered as staff attempt to establish rapport with potential clients and families will be provided by David Kuchinski. A licensed mental health professional will be assigned to oversee the outreach and referral process under Mr. Kuchinski including initial assessments of the potential client's eligibility for the program.

We will adhere to the following evidence-based practices for FEP services; Cognitive Behavior Therapy for Psychosis (CBT-p) and Individual Resiliency Training. All clinically appropriate and medically necessary services to persons experiencing their FEP will be provided by The Centers' clinical treatment team.

- CBT for Psychosis (CBT-p) -The Centers has three qualified mental health professionals trained in CBT-p as treatment for schizophrenia and related disorders which complement pharmacological and other psychological treatments. CBT-p creates a collaborative treatment alliance in which patient and therapist can explore distressing psychotic experiences and the beliefs that the patient has formed about these experiences.
- Individual Resiliency Therapy- The Centers has adopted the individual therapy component of the Recovery After Initial Schizophrenia Episode Early Treatment Program (RAISE-ETP). IRT uses a strengths-based approach that focuses on progress toward individual recovery goals, as well as improving social functioning and overall well-being.

Additional components of our coordinated specialty care approach to FEP will include making available the following services:

- Peer Support- The Centers will utilize individuals who live with mental illness to provide peer-to-peer support to others, drawing on their own experiences to promote wellness and recovery. Peer support will be based on mutual respect and personal responsibility and focus on wellness and recovery rather than on illness and disability.
- Psychoeducation- Family Psychoeducation will be provided as part of the overall clinical treatment plan by trained mental health professionals that are familiar with the concepts and general literature regarding schizophrenia including early warning signs, impact on functioning and the importance of early intervention. The service will aid and support family members in their reactions to their family members' problems as well as improving the treatment effectiveness for the persons with mental illness. Psychoeducation services will include education about serious mental illness; informational resources, especially during periods of crisis; skills training and ongoing guidance about managing mental illness; problem solving, and social and emotional support.
- Supported Education- Qualified behavioral health providers will provide supported education to help consumers participate in education programs to achieve recovery results. The services will help individuals find the right school, locate supports, manage disabilities and use new qualifications to seek employment.
- Supported Employment- Employment specialists at The Centers with strong clinical skills will provide clients with information that allows them to make informed career choices, achieve job accommodations and overcome cognitive impairments. Supported employment is guided by individual preferences and places the individual in competitive employment settings while providing ongoing coaching and support to increase the likelihood of successful work.

- Pharmacotherapy-The Centers adheres to our Chapter 63: Medication Management Policy to safely manage the effectiveness of medication of all clients and will continue to adhere to the policy for services under the proposed contract. Procedures include that all clients in higher levels of care seen by the physician will receive a medication assessment. In outpatient setting, clients who are seen by the physician for a psychiatric evaluation or are referred for medication management will receive a medication assessment (*refer to Attachment D for full policy*).

Outcomes related to FEP services including suicidality, psychiatric hospitalizations, substance use, prescription adherence, side effects of psychotropic medications prescribed, and the client's level of functioning with regards to ability to initiate/maintain involvement in educational setting, employment setting, and social connectivity will be tracked and clearly documented in the client's EMR. Ongoing assessment of suicidality for FEP persons will also be completed by the assigned clinician at each visit.

**E.3.G. Describe how your company will provide Community-Based Services and Support to your Clients within the Region you are proposing to provide services and describe your plan to meet the requirements in RFQ Section 2.3.2.G including but not limited to:**

**a. Develop and maintain local behavioral health and community resource directory, as well as community partnerships and collaborations with relevant agencies, stakeholders, and groups.**

Non-traditional services that are not Medicaid reimbursable will be made available to all children, youth and adults who demonstrate a need. This includes on-going public information and education campaigns and responses to community tragedy. The Centers will maintain a local Compassion Resource Directory that includes community partnerships and collaborations with relevant agencies, stakeholders and groups. We will publish the directory online, make it available in the Drop-In Center and share will critical partners including local PCPs, shelters, schools, hospitals and mental health clinics throughout Region 6.

Collaborative relationships exist between The Centers, LRCMHC and critical stakeholders in Region 6 including emergency departments, law enforcement, homeless shelters, people with lived experiences, crisis service providers, hospitals, schools, college and civic groups. We will lean on these relationships to disseminate information about available resources in central Arkansas.

**b. Demonstrate an on-going public information and education campaign to educate the local community with information about available resources, hours of operation, contact information, and how to access the agencies' services, including Crisis Services.**

The Centers has existing materials for marketing, outreach and awareness which details the services we provide, hours of operations and crisis service contact information. We will

continue to use those same outreach avenues and update our expanded services once we are awarded the proposed contract. We have a part-time marketing/outreach specialist who is very versatile to adjust mobile outreach based on emerging population needs. In the recent past, she shifted her outreach efforts to focus on the merging population needs of the Latino community. She uses a mix of face to face relationship building, networking, social media, web-based community resource listings, and bulletin board postings in targeted locations. She borrows from the outreach/awareness methodology from First Episode Psychosis best practices.

In order to meet our mission, our clinicians are trained to assess for and communicate to leadership the needs of the underserved in our community so we can shift or obtain resources as needed to meet these individualized needs. We will continue to use the network LRCMHC has developed to reach adults in mental health court, homeless shelters, domestic violence programs and libraries. As social workers have been hired in Little Rock libraries, we plan to offer services through that new role in central Arkansas library system.

**c. Demonstrate support of a Consumer Council, parent training, community response to tragedy, community resource center, and jail diversion.**

LRCMHC's existing Consumer Council is made up of consumers and 2 licensed mental health professionals with meetings held at Pinnacle House (Day Treatment Program) twice each month. This is an advisory based council that examines relevant laws and bills in relation to mental health. Members of the council discuss what role they want the council to take in the community and how they can advocate for change. The goal of the Consumer Council is to establish a productive, autonomous group that gives individuals a voice in their recovery and that works with the Mental Health Council of Arkansas to improve the states' mental health system. The Centers will support LRCHMC's existing consumer council and advocate for the Mental Health Council of Arkansas' partnership with NAMI to maintain the statewide consumer council.

The Centers' Little Rock Psychiatric Residential Treatment Program has an established consumer council to empower clients to have a voice in their recovery and help mold the program to meet their needs and preferences. A Consumer Council is also currently being implemented within our Day Treatment Program to offer a voice for the unique needs of these individuals as well.

The Centers' Consumer Councils are designed in a matter so that consumers may develop a strong and unified voice to influence and improve state policy decisions, further develop the consumer-led initiatives, impact local service development and forge productive alliances with community resources. These Consumer Councils were established based on the belief that having a more informed and involved consumer group will lead to a more responsive and relevant behavioral health system.

The Centers has provided community-based parenting education for over thirty years. Our Parent Center offers parenting education classes and an online parent resource library to build stronger

families within central Arkansas. Parent Education Classes are offered year-round on a variety of parenting topics which each session typically ranging from 4 to 6 weeks each. All courses are focused on enhancing parenting practices and behaviors, such as developing and practicing positive discipline techniques, learning age-appropriate child development skills and milestones, promoting positive play and interaction between parents and children, and locating and accessing community services and supports. Our online library features information on child development, parenting for good behavior, and more. We also have Parent Educators in the office during the week to field questions and provide guidance to those in need.

Non-traditional services community-based services and supports are also made available to all children, youth, and their families who demonstrate a need. This includes on-going public information and education campaigns and responses to community tragedies. The Centers has two licensed mental health professionals certified to teach Mental Health First Aid and provide this training to local schools, law enforcement, healthcare providers, churches and community members throughout Region 6.

LRCMHC conducts SPOE screenings in the Pulaski County jail and processes them through ASH to recommend more appropriate placement in a Crisis Stabilization Unit or inpatient hospital. The Centers will participate in LCRMHC's development of a formal jail diversion program in conjunction with Judge Martin and the Little Rock District Court and ASH. Our intention is to make sure individuals are assessed properly, that the crisis was resolved and that the individual is connected to an outpatient appointment or drop-in center services the following day. We are also committed to helping individuals' establish a support network and teaching them enough coping skills to help them deal with symptoms and connect with a local mental health center so they do not fall through the cracks after a crisis.

**d. Provide Community-Based Services and Support that are culturally competent, strength-based, and collaborative with community partners.**

It is the philosophy of The Centers that clients have access in a timely manner to comprehensive services, including community-based support, in order to address relevant physical, emotional, social and educational needs. Individuals are encouraged to participate to the fullest extent possible in the planning and delivery of services. Services are integrated, sensitive and responsive to cultural differences and special needs, and made available without regard for race, religion, national origin, gender, or other characteristics.

Care coordination ensures that multiple services are delivered within the community in a coordinated and therapeutic manner and that movement through the continuum of services is in accordance with changing needs. The rights of clients are protected and effective advocacy efforts promoted.

At the same time, The Centers follow a trauma-informed model of care that recognizes the interconnections between behavioral health challenges and unresolved trauma. Services are

based on the needs of the individual and follow the Six Key Principles identified by SAMSHA for Trauma Informed Care: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, cultural, historical, and gender issues.

**Vendors are encouraged, but not required to participate in the maintenance or development of Mental Health Courts. If you chose to pursue this, describe your plans to implement and staff the proposed collaborative effort, including the date when your agency will be able to serve Clients through this option.**

LRCMHC has been the Little Rock District Court liaison for Mental Health Courts for over 15 years. Licensed mental health professionals at LRCMHC have established relationships with local judges and prosecutors to advocate for jail diversion. They are present in Little Rock District Court on Wednesdays and Fridays to conduct substance abuse screenings and mental health evaluations. Based on the results, recommendations are made to the judge to court order appropriate treatment. The licensed mental health professional coordinates with the individual's treatment team and advocates for Section 9 if necessary; reports directly to prosecutors for non-compliance; provides supportive services to petitioners if needed and follows up with the court clerk as appropriate. SPOE screenings are also conducted for unstable inmates in the Pulaski County jail and processed through ASH or other inpatient hospitals.

For individuals involuntarily committed to Quapaw House for a 21 day detox stay, LRCMHC conducts on-site mental health evaluations; shares results with the individual; advocates for continued Section 9 if needed and follows them through the legal process to ensure appropriate outpatient and community-based services continue.

LRCMHC is currently in the process of establishing a formal jail diversion program with ASH and Judge Martin at the Little Rock District Court. This will be the first jail diversion program in Pulaski County and will identify individuals with SMI that are more appropriate for placement in treatment programs than jails.

**E.3.H. Describe how you will administer Social Services Block Grant (SSBG) Title XX Services within the Region you are proposing to provide services and describe your plan to meet the requirements in RFQ Section 2.3.2.H including but not limited to:**

**a. Make SSBG Title XX Services available to the SSBG Title XX Population of all Clients who meet the criteria outlined in the SSBG Manual (Attachment J).**

The Centers' currently subcontracts with LRCMHC to provide SSBG Title XX Services to children and youth who meet the criteria outlined in the SSBG Manual and LRCMHC provides SSBG Title XX Services to the adult qualifying population. Under the proposed contract, both The Centers and LRCMHC will make SSBG Title XX Services available to the SSBG Title XX Population of all Clients who meet the criteria outlined in the SSBG Manual.

**b. Administer traditional and non-traditional SSBG Title XX Services as described in RFQ 2.3.2. H.2.**

Traditional and non-traditional support and services under SSBG Title XX will be made available for all clients who are at or below one hundred percent (100%) of the federal poverty level in accordance with the requirements of the RFQ Section 2.3.2.H. In the performance of these duties, The Centers will provide allowable services in service code sections 29,38,43 and 56 of the most current version of the SSBG manual.

**c. Complete the DHS 100 Form.**

The Centers will ensure the DHS 100 form is completed on all clients accessing SSBG funding.

**E.3.I. Describe how you will ensure the provision and availability of Expanded Services within the Region you are proposing services and describe your plan to meet the requirements in RFQ Section 2.3.2.I including but not limited to:**

**a. Ensuring the following services are available directly or through a sub-contractor:**

i. Partial Hospitalization-Partial Hospitalization services will be made available to individuals in Region 6 through a subcontract with Ouachita (*refer to Attachment B for MOU*).

ii. Peer Support- Peer support specialists will include QBHPs with lived experience. The Centers' leadership team has seen first-hand the benefit of peer support services. Very often consumers develop instant report with individuals with lived experience and allow those individuals to assist them with in forging their path to recovery much more proficiently, which enables improved functioning and better success in life. The Centers is committed to building and sustaining a well-trained group of peers to provide youth, adult and family support services.

iii. Family Support Partner- Peer counselors at The Centers will model recovery and resiliency for caregivers of family members with behavioral health care needs. The peer counselors will be responsible for assisting, teaching, and modeling appropriate strategies and techniques, parental expectations and assisting families in securing community resources and developing natural supports.

iv. Supported Employment- Clients are empowered by finding their niche in the community, having purpose and meaning in their lives and being self-sufficient. Employment offers many collateral benefits that lead to improved functionality and self-confidence. The Centers is committed to utilizing and expanding this service as it offers meaningful and proficient outcomes. We have QBHPs on staff providing supported employment services. These services are designed to help clients acquire and keep meaningful jobs in a competitive job market, facilitate job acquisition by sending staff to accompany clients on interviews and providing ongoing support and/or on-the-job training once the client is

employed. Service settings vary depending on individual need and level of community integration and may include the beneficiary's home.

v. Supported Housing-The Centers and LRCMHC have QBHPs on staff trained to provide supportive housing services to develop and strengthen natural support in the community. LRCMHC currently operates five.(5) HUD grants that are based on a voucher program. Within these 5 grants, LRCMHC manages a total of 263 units with 450 beds within those units. As of March 1, 2019, 237 units are occupied are 421 beds as full. We will refer individuals in need of housing assistance to LRCMHC to ensure that individuals have a choice of permanent, safe, and affordable housing. QBHPS will assists clients in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey. Service settings may vary depending on individual need and level of community integration, and may include the client's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen and interacting with the criminal justice system. Based on experience, leadership recognizes the impact of securing supported housing for clients and offering the best practice support to assist individuals in maintaining their housing despite functional challenges and symptomology. This approach allows adults to live in the least restrictive setting and adds to their quality of life.

vi. Therapeutic Communities-The Centers will subcontract with Birch Tree Communities, Inc. for TC. We will also examine the feasibility of opening our own TC within six (6) months of the contract award and pursue this level of services if deemed necessary.

vii. Aftercare Recovery Support- The Centers' leadership team recognizes the importance of effective aftercare, acknowledging and adopting nationally recognized standards of care such as obtaining follow up appointments within 7 days, providing support to ensure medication adherence, and minimizing re-hospitalization within 30 days. These metrics are current performance improvement indicators at Centers and are analyzed ongoing. Aftercare Recovery Support is a part of The Centers full continuum of care and will continue to be offered under the proposed contract to recovering clients living in the community. Aftercare Recovery Support services include 1) educating and assisting the individual with accessing supports and services as needed 2) transitional services to assist the individual in adjusting after receiving a higher level of care and 3) providing training to assist the individual to learn, retain, or improve specific job skills, to successfully adapt and adjust to a particular work environment and to live in and maintain a household of their choosing in the community. QBHPs provide this service to recovering individuals with the goal of promoting and maintaining community integration.

**Vendors are encouraged, but not required to participate in the purchase of necessary psychotropic medication for individuals when there is no other payor source. If you chose to pursue this, describe your plans to implement and coordinate this service.**

The Centers will participate in the purchase of necessary psychotropic medication for individuals when there is no other payor source through our existing pharmacy provider, Healthcare Pharmacy. We currently contract with Healthcare Pharmacy to provide pharmacy services to all clients who so desire. This includes 24 hour emergency service by licensed pharmacists and pharmacy technicians. The pharmacist is a member of The Centers' Medical Management Committee and reports to the Medical Director.

The Centers' existing Pharmaceutical Services Plan outlines the procedures for administration of pharmaceutical services (*refer to Attachment D for full plan*). Adhering to these procedures provides the best and most appropriate method of obtaining, dispensing and administering medications, provides for the proper storage and disposal all medications and ensures all federal and state regulations are followed.

The pharmacy maintains the following schedule: Monday-Friday, 8:30-5:00. For emergency service after hours, clients can contact a pharmacist using the after-hours contact list.

We will also make pharmacy services available through our partnership with LRCMHC as LRCMHC's pharmacy is licensed as a community retail pharmacy. Medication Distribution services include dispensing/evaluation of medication prescription(s), which includes actual ingredient cost for all medically necessary prescriptions prescribed by a Licensed (ability to dispense) Medical Professional.

The Centers' has a staff psychiatrist, Dr. Hair, providing Medicated-Assisted Treatment (MAT) to clients in need of this service. This "whole-patient" approach to the treatment of substance use disorders uses FDA- approved medications, in combination with counseling and behavioral therapies. We will also refer individuals in need of this service to Recovery Centers of Arkansas (*refer to Attachment C for MOU*). RCA employs two psychiatrists licensed to provide this service.

## E.4 COMMUNITY COLLABORATIONS

**E.4.A. Describe how your company will develop community collaborations and partnerships and your plan to meet the requirements in RFQ Section 2.3 within the Region you are proposing services including but not limited to:**

**a. Collaborate with diverse stakeholders within the proposed Region.**

The Centers has an established reciprocal referral working relationship with Recovery Centers of Arkansas (RCA) that reinforces our No Wrong Door model of care and will continue to collaborate with RCA to ensure evidence-based substance abuse and re-entry services are

available to clients under the proposed contract. RCA is a CARF accredited substance abuse treatment program operating in the Central Arkansas area. The non-profit organization is licensed by the state of Arkansas for Behavioral Health and Substance Abuse Treatment and provides traditional individual, group and family treatment services. A 30-bed chemical-free living facility offers those individuals who need extended services for those in an early stage of recovery. To further support a successful recovery the organization offers aftercare services at no additional cost.

Evidence-based practices used at Recovery Centers of Arkansas include trauma-informed care, TCU Mapping, Motivational Interviewing, Seeking Safety, Matrix, Cognitive Behavioral Therapy, Living In Balance and Smoking Cessation.

The American Society of Addiction Medicine (ASAM) criteria is used in making placement recommendations. ASAM recommends placement in the least restrictive environment. Individuals are recommended for residential treatment if they carry a severe substance use disorder diagnosis and have been determined to be unable to discontinue using in an outpatient setting. Otherwise, placement recommendations are for outpatient services with intensity and duration dependent upon the severity noted on the diagnosis. Recovery Centers of Arkansas provides a full spectrum of level of treatment to meet the needs of the individual with a substance use disorder: Residential Treatment, Day Treatment/Partial Hospitalization, Intensive Outpatient Services, Outpatient Services. All levels of care include a drug testing component. A strong aftercare program is available at no additional fee for program alumni. RCA is also licensed by Arkansas Department of Community Corrections as a re-entry program. Specific program that provides for the early release of from the Arkansas Department of Corrections.

Recovery Centers of Arkansas' staff includes waivered psychiatrists (in conjunction with its Medication Assisted Treatment program), master's level social workers and licensed counselors, licensed alcohol and drug counselors, certified alcohol and drug counselors and trained peer recovery support specialists. (*Refer to Attachment C for MOU).*

A partnership with Friendship Community Care exists to ensure seamless referrals are made for Developmentally Disabled services. CBHFCC is Arkansas's largest statewide provider of humanitarian care to families navigating life with disability. They offer child and adult development programming for individuals with developmental disabilities. We will refer individuals in Region 6 to the following CBHFCC's programming: Adult Day Treatment, Prevocational Training and Employment, Job Path, Project Search, Residential Living, Developmental Preschool and Outpatient behavioral Health Services.

We remain committed to educating our local community on trauma-informed care to reduce the stigma of mental health and ensure the services are based on the needs of the individuals. We have and will continue to conduct external trauma-informed care training with community organizations including schools, first responders, hospitals and law enforcement.

**b. Collaborate within the community to assist with assistive outreach, Early Intervention, and stabilization of individuals who may reside in jails, be hospitalized, experiencing a FEP, or have re-occurring crises.**

The Centers is committed to early intervention to ensure individuals receive evidence-based services in the least restrictive setting. The Centers and LRCMHC lean on First Episode Psychosis best practices for outreach and early intervention strategies. Leadership is experienced with operationalizing Individual Resiliency Training for adults with mental illness. Our full continuum of services for children, adolescents and adults has given us the experience and resources to provide early intervention in the office, home, school and community. We understand the impact of stigma on seeking mental health assistance and need the need to provide education and "wraparound" services to keep clients in the community as symptoms and or behavioral/emotional issues develop. We are willing to serve clients where they are, functionally, geographically and based on their level of engagement. Our QBHP's serve clients in their classroom and provide services in the home for clients, parents and therapeutic foster parents. We are culturally sensitive with our outreach, for example we have found the value in hiring Spanish speaking clinicians who can develop culturally sensitive relationships with Spanish speaking clients who may be somewhat "reluctant" to seek help outside the family. We commit to provide pertinent best practice interventions for individuals in jail, advocate for treatment as appropriate and partner with LRCMHC with their current mental health court and jail diversion strategies. The Centers has protocols in place to utilize early intervention as a means to curb potential crisis and minimize hospitalization. We used "hospitalization within 30 days" as a performance indicator and we use a relapse prevention strategy to build off of protective factors, strengths and enhanced coping skills to avert crisis' and re-hospitalizations. Leadership actively explores alternative placement options or strategies to keep individuals in the least restrictive setting possible.

**c. Assist in developing short and long-term solutions to help individuals connect with community supports.**

Clinicians at The Centers are trained in the Neal Adams treatment planning approach which has a specific component focusing on the importance of acquiring natural supports for clients to assist them in increasing their functionality and decreasing dependence on the mental health provider. Research shows that "extra therapeutic factors-natural supports" (such as finding a church home, participating in sports teams, finding a significant other, etc) account for as high as 40% of change/improvement in treatment. The Centers is dedicated to assisting clients in identifying natural supports to support their individual recovery and expanding community resources to offer more choice to our clients.

LRCMHC also help individuals connect with community supports through their PATH grant. Supportive services, both inreach and outreach, are provided to homeless populations in Region 6 who are either living on the street or in homeless shelters. The purpose of this initiative is to

get individuals plugged into the mental health system and to provide needed assistance that eliminates barriers to care. For example, transportation assistance is provided in the form of bus passes and individuals can use funding to cover medication co-pays, birth certificate and identification fees and clothing. The long-term goal of the grant is to assist individuals in becoming stable and supported so that they can find employment and stable housing. Local partners on this initiative include Woman and Children First, Dorcas House, Jericho Way and Our House.

**d. Focus on developing collaborations to prevent deterioration of Clients and enhance Clients' functioning and provide community members with a full array of medically necessary behavioral health care services.**

The Centers sees our continuum of care expanded beyond our treatment services to include our partner network. Our ongoing assessment process will include the specialty services of our partners as options within our perceived treatment continuum. These expanded services will also offer increased client choice and alternative treatment options. Our partners are committed to No Wrong Door principles and make referrals processes seamless to benefit the client needs regardless of payor.

**e. Develop partnerships with child and youth serving agencies and family organizations to avoid children and youth being placed outside their home and community.**

The Centers has been a child and youth serving agency committed to well-being of families since 1884. We have existing partnerships, including those with DCFS, where the shared goal is to avoid children and youth being placed outside their home community.

We contract with an external evaluator, Centerstone Research Institutive, to determine outcome salutations based on clinical care provided by The Centers. Our most recent progress report from October 31, 2018, reflected a snapshot of the stability of children receiving services from The Centers at three different time points: (1) the beginning of treatment, or baseline, (2) three months into treatment, and (3) six months into treatment. Most children were in the custody of a single parent or in Department of Children and Family Services (DCFS) custody. The majority of these children were living in a semi-permanent or permanent residence at baseline. At the three and six month follow-ups, clients' living situations and custody status frequently remained the same, suggesting that many children were in stable home environments, though some children moved out of DCFS custody into parent or family custody.

We remain committed to keeping children within their home community and work extensively in our Therapeutic Foster Care Program to recruit, train and support therapeutic foster families in Arkansas. Increasing the number of therapeutic foster homes in the state is a critical need as this will ensure children in foster care are placed in a safe, loving foster home in the community they are familiar with as opposed to being shuffled to another county with an available foster home.

We also provided mental health services to children in therapeutic foster care and supportive services for families.

We collaborate with additional child and youth serving agencies in Region 6 including the Children's Protection Center, the Arkansas Home Visiting Network and the Little Rock School District.

## E.5 STAFFING REQUIREMENTS

**E.5.A. Describe your company's staffing plan for the Region you are proposing to provide services and how you will ensure the services you render to Clients are provided within the**

The Centers makes every effort to base its staffing levels and assignments on a variety of factors including the following: staff qualifications, the physical design of the environment, diagnoses, co-occurring conditions, acuity levels, and age and developmental functioning of clients. We have maintained an adequate staffing pattern throughout our history and do not foresee any shortage in staffing patterns for the proposed contract. We are able to adjust programs and staff accordingly to meet staffing ratios. We have many tenured staff members who have been cross-trained and could transition to new services or programming under the proposed contract. We will also provide the necessary personnel to provide services in the community.

Further, our relationship with LRCMHC enhances our staffing capabilities we are able to share resources, staff and cross-train employees.

In addition to having qualified and trained staffed, The Centers has an existing Chapter 61: Clinical Supervision Policy in place (*Refer to Attachment D for full policy)* to ensure quality treatment, excellence in documentation and to meet licensure/board requirements of clinicians and Medicaid, Division of Behavioral Health regulations. The Medical Director and Chief Clinical Officer provide clinical supervision to program managers who provide clinical services. Documented client-specific face-to-face communication regarding client care occurs between each clinical supervisor and the clinician at least every ninety (90) days.

**a. Describe your policies and procedures for training all staff and tracking the training requirements.**

The Centers' Staff Development Plan, ORG-19 (*Refer to Attachment D for full plan)* ensures that all employees are provided with opportunities to develop, maintain, and improve their job knowledge, skills, and abilities. Training represents an investment of time and money in each employee. Each employee is required to obtain the number of training hours as determined by the licensing agency of the department/division, plus other training sessions based on an identified training need (a minimum of 30 hours for direct care and a minimum of 10 hours for support staff).

A multidisciplinary committee meets on a yearly basis to review the staff development plan and make suggestions for additions or deletions based on agency needs, changing regulations, and financial considerations.

The goals of training are as follows:

- To keep current all required certifications, i.e., Behavior Management, CPR, First Aid
- To keep staff abreast of current research, methods, or other information in their particular area
- To encourage staff to grow in knowledge and experience by offering opportunities for self-enhancing training
- To ensure that clients receive services in a safe environment
- To improve competency and knowledge based in specific areas pertinent to staff roles
- To ensure only medically necessary services are provided with proper documentation

Staff Development Opportunities offered to all employees during new employee orientation:

- The organization's mission and goals
- Cultural diversity and sensitivity
- Signs of abuse and neglect
- Rights of clients and ethical aspects of care, treatment, and services and the process to address ethical issues
- Code of ethics
- Mandated reporting
- Safety, body mechanics, infection control
- Confidentiality
- Equal Employment Opportunity
- Corporate Compliance
- Health Insurance Portability and Accountability Act
- Relias Learning
- Trauma-Informed Care
- Therapeutic Boundaries

Program Specific Orientation includes:

- Specific job duties and responsibilities
- Service, setting, or program-specific job duties and responsibilities related to safety and infection control
- Incident reporting/Unanticipated adverse events
- Road test if staff is to transport clients
- When job duties or responsibilities change, training specific to changed duties/responsibilities occurs

QBHP, Education Therapist, Nursing Staff

*Agency Orientation*

- QBHP - 40 hours
- Suicide Prevention and Intervention
- Human Trafficking
- Developmental Milestones
- Behavior Management Program to include underlying causes of threatening behavior; aggressive behaviors related to medical conditions; staff effect on client behavior; recognizing and interpreting signs of physical distress in clients who are being held or secluded; recognizing the effect of age, developmental level, gender, ethnicity and history of abuse; the correct use of time-out protocols. (Competency assessment to include written tests to be placed in each staff member's staff development file)
- CPR and First Aid

*Program Orientation*

- Behavior management and point/level systems
- Progress Reporting
- Sexual Adjustment as required by program/unit
- Driver Training

Additional educational requirements for nursing:

- Documentation (department orientation)
- Nursing interventions to DSM V (department orientation)
- Nursing interventions related to the developmental stage of children and adolescents (department orientation)

Supervisors & Managers

*Agency Orientation*

- Agency policies - Human Resources (e.g., legal issues, CYF Personnel policies and procedures)
- Human Trafficking
- Developmental Milestones
- Behavior Management Program (clinical programs only) to include underlying causes of threatening behavior; aggressive behaviors related to medical conditions; staff effect on client behavior; recognizing and interpreting signs of physical distress in clients who are being held or secluded; recognizing the effect of age, developmental level, gender, ethnicity and history of abuse; the correct use of time-out protocols. (Competency assessment to include written tests to be placed in each staff member's staff development file).
- CPR and First Aid

*Program Orientation*

- Behavior management and point/level system (clinical programs only) to be presented as a part of program orientation

Clinical

*Agency Orientation*

- Behavior Management Program to include underlying causes of threatening behavior; aggressive behaviors related to medical conditions; staff effect on client behavior; recognizing and interpreting signs of physical distress in clients who are being held or secluded; recognizing the effect of age, developmental level, gender, ethnicity and history of abuse; the correct use of time-out protocols. (Competency assessment to include written tests to be placed in each staff member's staff development file)
- Human Trafficking
- Developmental Milestones
- CPR and First Aid

*Program Orientation*

- Clinical Orientation
- Treatment Planning Process
- Behavior management and point/level systems
- DSM-V (annually) to include multi diagnosis and Rule Out criteria
- Appropriate interventions per diagnosis
- Unanticipated adverse events
- Documentation requirements and legalities
- Substance abuse issues
- Sexual abuse issues
- Medications used for various disorders and side-effects
- Foster care and adoption issues
- Play Therapy or Theraplay - as designated by supervisor
- Group Therapy – as designated by supervisor
- Opportunities for clinical training at Clinicians' meetings
- Monthly modules for new clinicians (as needed)
- Dietary, Housekeeping, Maintenance

*Program Orientation*

- Regular training by the Facilities Manager for housekeeping staff on the use of chemicals, proper cleaning methods, OSHA regulations, etc.
- Regular training by the Facilities Manager for maintenance staff on issues related to proper maintenance of facilities and equipment

Required Refresher Training

Specific refresher training is required of all staff, and additional refresher training of certain staff depending on their job responsibilities. The table below outlines this required training. Staff may be suspended without pay if training is not completed in a timely fashion.

| **Training** | **Staff required to complete it** | **Format of training** | **Schedule** |
|---|---|---|---|
| Behavior Management Program | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Presentation by staff development trainer with competencies assessed at the end of session - tests filed in individual staff development files | Every six months<br><br>TFHP – annual |
| CPR and First Aid | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Presentation by staff development trainer with competencies assessed throughout the session | Annually<br><br>TFHP – Every 2 years |
| Corporate Compliance including a conflict of interest statement | All staff of The Centers | Relias Learning; Conflict of Interest Statement signed at the conclusion of each fiscal year | Upon hire and annually thereafter |
| Incident Reporting/ Unanticipated Adverse Events | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Relias Learning | Annually on Relias Learning |
| Suicide Prevention and Intervention Refresher | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Presentation by staff development trainer | Upon hire and annually |

Tracking

The Risk Management Department is responsible for tracking all staff development hours of staff.

- Staff compliance with number of required hours is addressed by the supervisor during the annual performance evaluation process.
- Staff failing to complete required training may be suspended without pay until such time as the training is successfully completed.

**c. Describe your ability to demonstrate on-going staff development and recruitment.**
The Centers Staff Development Plan defines our system for ongoing staff development and ensures appropriate orientation and training programs are provided for all administrative, clinical and support personnel and are designed to meet needs identified in the quality assessment and improvement process (*refer to Attachment D for full plan*).

This policy guarantees that employees are provided with opportunities to develop, maintain, and improve their job knowledge, skills, and abilities. Required training, elective trainings and external conferences and workshops are included components of the policy.

**d. Describe your efforts to ensure all staff are good stewards of state and federal funds.** The Centers' has an established Chapter 34: Fiscal Policy (*Refer to Attachment D for full policy*) that outlines the role of The Centers' Board of Directors in governing and management all services and being accountable to the general public and the various funding sources (including state and federal funders) for the allocation and use of its financial resources.

Out agency has an impeccable track record of being good stewards of state and federal funds. Written accounting and fiscal control procedures are in place to safeguard agency assets and to ensure accuracy of financial data. The Centers maintains a contract with an independent C.P.A firm to complete an annual financial audit that is in accordance with auditing standards generally accepted in the United States of America; Government Auditing Standards, issued by the Comptroller General of the United States; and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. A separate cost center is maintained for each program within each division and the current financial status of each program is reviewed monthly by the program manager, the CFO, and the Operations Committee of the Board of Directors. The Centers has a longstanding history of successfully managing state contracts and federal grants and has been reviewed by regulatory agencies as having strengths that included complete financial policies and procedures, grant funds that are easy to track to a specific program and financial status reports that were submitted in a timely manner.

## E.6 RECORDS AND REPORTING

### E.6.A. Describe your company's policies and procedures related to Client records and record retention including:

The Centers maintains a Chapter 44: Client Records Policy that is review annually by the Board of Directors (*refer to Attachment D for full policy).* The purpose of the policy is to ensure a complete chronological record of each client's episodes of care are documented in a timely and accurate manner. A client record is maintained for each client from the day of admission to the day of discharge. It is The Centers' policy that client information is maintained for a period of 10 years from the discharge date for adult clients and a period of 10 years after minor clients have reached the age of 18.

In order to ensure the security and confidentiality of the client record, The Centers adheres to strict guidelines relating to chart access. The extent of access is determined in accordance with The Centers' Privacy Plan.

To safeguard against destruction, our client record department has back-up copies of records on CD Rom disks. These disks are stored at a separate site from the department and building which houses the client record department. New employees of the agency receive education concerning the contents of the Client Records Policy during new employee orientation.

**a. A description of the electronic medical records system you use and what documentation is captured in the electronic medical records system.**

Both The Centers and Little Rock Community Mental Health Center use Credible as our electronic medical records system. Credible is a behavioral health enterprise software that provides us with a secure, web-based health record platform. Within our electronic medical records system, a clinical record is developed and maintained for each client who receives assessment and/or treatment in any component of The Centers. All documentation is assembled and located in one central record, unique to the client, thereby constituting a unit record. Documentation is maintained in a standardized format and arranged in a standardized sequence. All clinical documentation forms must be completed by the assigned licensed clinician.

The following documentation is captured in the EMR system:

- Admissions
- Initial Psychiatric Diagnostic Assessment
- Psychological Evaluation
- Mental Health Evaluations
- Master Treatment Plan
- Transfer Summaries
- Treatment Plan Reviews
- OBHS Services
- Discharge Summaries
- Laboratory Tests
- Legal
- Medical
- Physician Orders
- Progress Notes
- Referrals
- Substance Abuse Treatment
- Therapeutic leaves
- Wrap Around Services
- Other clinical documentation requiring the signature of a licensed professional

- Forms

**b. How you plan to document all services rendered via the Contract's funding sources and report this data to DHS in the DHS-approved format and timeframe.**

All services rendered via the contract's funding sources will be documented in our existing medical records system, Credible. The Centers will bill only for medically necessary services that have been performed and correctly documented.

In accordance with our existing Chapter 68: Documentation of Service Provision Policy (*refer to Attachment D for full policy)* all service entries will contain, at a minimum, the following information:

- Client name, date of birth and social security number
- Services provided
- Date and actual time of service rendered (time in/time out)
- Name and credentials of individual providing services
- Setting in which the services were rendered
- Relationship of the services to the treatment regimen as described in the Treatment Plan
- Updates describing the client's progress

The Centers will maintain all pertinent financial and accounting records and evidence pertaining to the contract in accordance with generally accepted principles of accounting and as specified by the State of Arkansas Law. Upon request, access will be granted to State or Federal Government entities or any of their duly authorized representatives. Financial and accounting records will be made available, upon request, to the State of Arkansas' designee(s) at any time during the contract period and any extension thereof, and for five (5) years from expiration date and final payment on the contract or extension thereof.

## E.7 APPEALS AND GRIEVANCE PROCESS

**E.7.A. Describe your plan for providing a system for handling individual complaints and appeals, and cooperating fully with the processing of any complaint or appeal.**

Chapter 45 of The Centers' policies and procedures outlines our Client Grievance Policy (*refer to Attachment D for full policy)*. This policy provides clients and their families with a process to complain or grieve concerns regarding treatment. The procedures are as follows:

Client Notification
As part of the admission process, all clients and their legal guardians shall be informed of their right to express any concerns they may have regarding services at Centers for Youth and Families. Written documentation will be included in the client record that the client and legal guardian have been advised of the grievance process.

Client Complaint Review

All issues/concerns identified by a client/guardian will be addressed by the manager of the program where the issues/concerns were identified. All staff members shall be responsible for assisting clients and/or their legal guardian in expressing their concerns in writing. Once a complaint has been received, it should be forwarded to the program manager, within 48 hours or the next business day (whichever occurs first). The program manager shall respond to the client and/or legal guardian's complaint within 72 hours of receiving it.

Client Grievance Review

In the event that the concern cannot be resolved at the program level, the program manager will refer the client and/or legal guardian to the Director of Risk Management in order to file a formal grievance. The Director of Risk Management will interview the party wishing to file the grievance in order to determine the nature and scope of the grievance. The COO and Medical Director will be notified of the nature of the grievance. The Director of Risk Management in conjunction with the program manager will determine who should conduct an administrative review of the grievance.

That individual has 72 hours to review and attempt to resolve the matter. If the matter cannot be resolved within 72 hours, the reviewer must notify the Clinical Operations Director and Medical Director of the estimated time needed to complete the investigation.

Once an administrative review has been conducted and recommendations made, the disposition of the grievance will be provided to the COO and Medical Director. In the event that the grievance cannot be resolved by administrative review, it will then be forwarded to the CEO for resolution. If the grievance cannot be resolved by the CEO within 3 business days, it shall be forwarded to Centers' attorney for recommendations, if necessary.

Agency Review

All client complaints are reviewed on a program level. Program Managers document the disposition of all client complaints. This information is available for review by agency administration and a summary version presented to the Performance Improvement Committee. All client grievances are reviewed by the Director of Risk Management who seeks input from the CEO if needed. These grievances may then be forwarded to the Performance Improvement for additional review as necessary.

External Review

A client and/or legal guardian have the right to express to external organizations, complaints regarding the quality of services received. The Centers' staff are responsible for directing a client's and/or legal guardian's complaint to external organizations, as appropriate. Each program will identify for the legal guardian, in writing, those external organizations which accredit or license their program. Notification, if made by the program, will be documented in the client record.

Documentation
All documentation regarding client complaints shall be maintained by the Program Manager. This information shall be maintained in a log that is available for external review, if necessary. A copy of all completed complaints are forwarded to the Risk Management Office.
All documentation regarding client grievances shall be forwarded to the Director of Risk Management for ensuring the integrity of the grievance process and shall contain the following information:

- Identity of the client and/or legal guardian initiating the complaint or grievance
- Specifics of the complaint or grievance
- Efforts to resolve the complaint or grievance, and
- Results of efforts taken to resolve the complaint or grievance

Notification
All client grievances regarding quality of service shall be forwarded to the Medical Director for review.

Complaints Regarding Violations of HIPAA Regulations
All complaints of violations regarding disclosure of protected health information should be referred to the Centers' Privacy Officer at 666-8686 X 1550.

## E. 8 QUALITY ASSURANCE

**E.8.A. Describe how you will develop and utilize quality assurance and quality improvements methods to ensure that the appropriate services and treatments for Clients with the most serious behavioral illness, including those with re-occurring crises, hospitalization, and emergencies, are receiving the most effective and efficient treatment modalities available.**

The Centers is adopting the HEIDIS outcome measures to ensure clients with serious behavioral illness are receiving the most effective and efficient treatment modalities. Adopting and tracking HEIDIS indicators pertinent to our treatment focus give us objectives to work toward to be a more effective treatment organization and to ensure treatment delivered yields measurable improvements. HEIDIS outcome measurement will simultaneously enhance our performance improvement process and yield high consumer satisfaction ratings.

We also contract with Centerstone Research Institute, an external evaluator, to apply Outcome Solutions as a means to collect data about the impact of services on the lives of families and youth accessing our mental health care services. The Centers conducts an ongoing planning and evaluation process to ensure optional provision of services consistent with the philosophy and goals for our agency. The guidelines for services and administrative operations are developed

from information representing referral demands and needs identified by referral sources, review of The Centers mission statement as related to community needs, establishment of service priorities and available resources to respond to identified needs.

## E.9 VENDOR COMPENSATION AND FINANCIAL MANAGEMENT

**E.9.A. Describe how it will comply with the requirements set forth in RFQ Section 2.9 regarding utilization of funds provided by DHS:**

**a. Attest you shall utilize DAABHS funds only for the populations defined in RFQ Section 2.3.2.**

The Centers attest that DAADHS funds will only be utilized for the populations defined in RFQ Section 2.3.2; including all individuals experiencing psychiatric or behavioral crises without a payor source for medically necessary services in Region 6 and for all persons in the custody of DCFS who are not a member of a PASSE.

**b. Describe how you will keep receipts of purchases for SSBG Title XX services and send billing to DHS monthly according to the SSBG Block Grant Manual (Attachment H).**

Receipts of purchases for SSBG Title XX services will be kept in our behind double locked doors in our administrative office located at Suite 101 of The Freeway Medical Tower at 5800 West 10th Street, Little Rock Arkansas. Billing to DHS will be sent monthly by Alaina Bolden, Grants Manager each month according to guidelines established in the SSBG Block Grant Manual.

**c. Describe your ability to bill private insurance plans, Medicaid, Medicare, and Veterans Administration benefits and how you will ensure you bill these payor sources when an individual is enrolled such that contracted funds will be the payor of last resort.**

The Centers and LRCMHCs billing software within our Electronic Medical Records system, Credible, is set up to bill private insurance plans, Medicaid, Medicare, and Veterans Administration benefits as primary payers ordering of the payers within our software. If a client qualifies for contracted funds, the contract payer would be set up as last resort (last in the ordering of payers).

**d. Attest you shall undergo an annual audit conducted by a certified public accounting firm.**

The Centers maintains a contract with an independent Certified Public Accounting firm to complete an annual financial audit this is in accordance with auditing standards generally accepted in the United States of America; Government Auditing Standards, issued by the Comptroller General of the United States; and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. A separate cost center is maintained for each

program within each division and the current financial status of each program is reviewed monthly by the program manager, the CFO, and the Operations Committee of the Board. The Centers has an excellent history of successfully managing contracts and has been reviewed by regulatory agencies as having strengths that included very complete financial policies and procedures, contract funds that are easy to track to a specific program and financial status reports that were submitted in a timely manner.

**e. Describe how your agency will utilize funds toward the development of infrastructure.**

The Centers and LRCMHC can accommodate providing services under the proposed contract within our existing physical property in Little Rock and through subcontract agreements with local providers. If extra space is deemed necessary at any point throughout the contract, The Centers' CEO will investigate available building leasing opportunities in Region 6. We will continue to invest in the development of infrastructure including staff retention, training and IT upgrades to ensure we stay abreast of evidence-based practices, recruit and maintain adequate staffing and increase efficiency through the use of the latest technology and electric medical records system.

The Centers' current physical infrastructure in Region 6 includes:

- 6601 West 12th Street Little Rock, Arkansas 72204
- 6501 West 12th Street Little Rock, Arkansas 72204
- 6425 West 12th Street Little Rock, Arkansas 72204
- 5800 West 10th Street, (Suite 101, 402, and 600) Little Rock, Arkansas 72204

## E. 10 REGION SPECIFIC SERVICES

**E.10.A. Submit a narrative that describes how you propose to perform the RFQ required services in your desired Region.**

**a. Describe your specific community collaborations in each county within this Region. Include copies of Memorandum of Understandings, and any other formal or informal agreements, or letters of support from community partners in your Region to demonstrate solid community partnerships and collaborations.**

The Centers and LRCMHC collaborate with the following community partners in Region 6 and will continue to collaborative with these critical stakeholders under the proposed contract:

| Type of Service | Partners |
|---|---|
| **Shelter** | Jericho Way, Our House, Women and Children First, Immerse Arkansas, Dorcas House |
| **Substance Abuse** | Recovery Centers of Arkansas, Quapaw House, Better Community Development |
| **Mental Health** | PRI, Mid-SOUTH, Ouachita Behavioral Health, The Bridgeway, Inspiration, Inc. |
| **Child Welfare** | DCFS, Children's Protection Center, Rite of Passage |

| | |
|---|---|
| **Developmentally Disabled** | Connections Behavioral Health powered by Friendship Community Care |
| **Hospitals** | ASH, UAMS, St. Vincent's, Arkansas Children's Hospital, Baptist Medical Center |
| **Education** | Little Rock School District, Pulaski County Special School District, Arkansas Department of Education |
| **Physical Health** | Arkansas Home Visiting Network, local Primary Care Clinics |
| **Acute Crisis** | Pulaski County Crisis Stabilization Unit, Pinnacle Pointe, Methodist Behavioral Health |
| **Legal** | Little Rock Police Department, Little Rock District Court, Pulaski County Jail, Pulaski County Juvenile Detention Center |
| **Advocacy** | Mental Health Council of Arkansas, NAMI, Arkansas Advocates |
| **Vocational Preparation/Employment Training** | Our House, Goodwill |

**b. Describe any unique challenges you see within this Region and how you will address them and explain why you are particularly well suited to provide services in the Region.**

The Centers is particularly well suited to provide services in Region 6, as well have had a presence in the region for over 135 years. We are known as a premiere provider of behavioral health services for both children and adults in Pulaski County. Of clients served in 2017, the majority, 2,200 were from Pulaski County. Our central offices are located in Little Rock and we have existing partnerships throughout the region. In similar fashion LCMHC and its predecessor organization, GLRCMHC, has had a presence in since 1965 serving persons with serious behavioral disorders and working in conjunction with other organizations to both create and improve a broad range of social, health, and housing resources in the community.

Further, our relationship with LRCMHC will address our current challenge of delivering services to targeted populations of adults. We will rely on LRCHMH's expertise to seamlessly deliver client-centered services to adults. In this current year LRCMHC has served 2,555 individuals experiencing a broad range of psychiatric disorders. In addition, LRCMHC has provided housing to over 240 individuals and households formerly homeless and behaviorally disordered.

The Centers and LRCMHC have the demonstrated capacity to secure, implement and manage both federal and local grant funding to address "gaps" in needed services for vulnerable populations. We will continue to solicit additional grant funding to ensure we provide superior care and connect individuals' with the resources and services needed to keep individuals with serious and persistent mental illness healthy and living in the community of their choice.

Both organizations have a long history of working in a collaborative fashion with other community organizations and stakeholders in the Region. While Medicaid funding has been a mainstay in provision of direct therapeutic intervention for SED and SMI populations both organizations are experienced in leveraging resources necessary to recovery beyond treatment. LRCMHC and The Centers are founding members of the homeless service coalition where a

continuum of care in central Arkansas to serve individuals and families is an ongoing goal. The homeless population in central Arkansas remains an ongoing challenge for the community but particular for behavioral health organizations as the percentage of individuals with psychiatric disorders and behavioral problems remains constant at 35% to 40%. LRCMHC program advocacy efforts have been successful in supporting general homeless program to adapt their resources for not only basic needs but also transitional and vocational resources to include this underserved population.

Whether through our partnerships with Our House or Jericho Way, constant outreach and support has created an acceptance of persons with behavioral disorders in these mainstream programs. LRCMHC has worked with the City of Little Rock's efforts to develop a systemic approach to homelessness beyond only food and shelter but also to address prevention and early intervention. Likewise, LRCMHC working with local law enforcement and state authorities has participated to large CIT training and is open to a third. The Centers and LRCMHC strongly support provision of targeted trainings to develop awareness and better understanding among officers of mental illness and the resources available in the community. As with the homelessness and the immediate need for shelters, The Centers' and LRCMHC's advocacy is directed toward a supporting a diverse array of resources beyond a brief crisis stabilization or detoxification where individuals can find resources that best suit their needs in a more permanent and last way.

Homelessness is an example of the distinct difference in Region 6, and why both Centers and LRCMHC along with their partners, have both the experience and understanding to provide services in this Region. The causes of homelessness are at the heart of making the correct choices in both program management and service development. Understanding breakdowns in Continuity of Care due to inadequate discharge policy is a major factor in creating chronic homeless and this realization has caused LRCMHC to invest heavily the PATH model of prevention and early intervention as well as building a housing resource based independent housing as opposed to only group type of residential resources. Providing only brief access to 24 hour care for behavioral crisis is not enough to reduce recidivism or chronicity. Continuous post discharge care is crucial in recovery where positive outcomes reinforce the importance of a plan and compliance with the plan.

On a given Friday in Region 6, by far more discharges occur from psychiatric inpatient programs than several if not all other regions combined. The coming of the PASSEs and Medicaid reimbursement containment will likely accelerate this number of discharges. Unfortunately, rapidity and increased numbers of discharges will impact entitlement coverages and will likely create increased indigent status. Both LRCMHC and The Centers have an understanding of this issue and the required management to prevent this impact while at the same time prevent a relapse due to a brief lapse in coverage and discontinuity. An ongoing communication with the Region 6 inpatient services is crucial is maintaining this continuity for indigent patients and the incentive is of course good care, but more, it is prevention of chronicity and higher long term cost. Again LRCMHC and The Centers understand Regions 6's benefit of having a large number

of 24-hour accessible resources but also the service management challenge in ensuring a lasting benefit by an "Open Door" to post hospital care.

Under other sections forensic and courts have been addressed, but to restate LRCMHC and The Centers are prepared to work actively with DAABHS in improvement of all forensic services in Pulaski County whether the District Court in a modified Mental Health Court initiative or a seamless process of rapid access to Forensic evaluations, and where appropriate, admission or continuance of Outpatient treatment. LRCMHC and The Centers are also interested in further discussion of 24 hour stabilization alternatives. A specialized partial hospitalization resource is also a topic LRCMHC and The Centers are willing to explore in a discussion of alternative resources.

In summary, LRCMHC and The Centers offer joint experience, particularly when our relationships with community partners are combined, that provides the capacity to meet the challenges in this Region. South Pulaski County, due to the many challenges of being the State's only true urban area, offers an opportunity with this funding initiative to improve service delivery while seeking a partnership involving both the State and community stakeholders to address needed improvements in both access and availability of recovery-focused behavioral healthcare.

# Attachment A

# Letters of Recommendation

**HERBERT T. WRIGHT, JR.**
Circuit Judge
401 West Markham, Suite 440
Little Rock, AR 72201
Phone: (501) 340-8593
Fax: (501) 340-8822

SIXTH JUDICIAL CIRCUIT
FOURTH DIVISION

PULASKI AND PERRY
COUNTIES

March 12, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main St., Slot W345
Little Rock, AR 72201

Re: Bid Number: 710-19-1024

To Whom It May Concern:

I am writing in support of Centers for Youth and Families and Little Rock Community Mental Health's application for State funding so that LRCMHC and CYF can continue to provide mental health services to the poor and underserved in the Greater Little Rock Area as well as forensic and crisis services for those in need.

I am familiar with the services offered by CYF and LRCMHC, including Crisis and Community Intervention, Forensic Services, Community Based Rehabilitation, and Outpatient Services. As a judge who handles a criminal docket and part of the docket at ASH Mental Health Court, I can say that these organizations help the individuals who would otherwise be missed by the system.

The number of people in the criminal justice system there because of mental illness or other psychological deficits is sometimes staggering. The system could not operate without organizations like LRCMHC and CYF. They not only help the individuals who suffer with mental illness, but the community as a whole.

I would encourage any funding agency reviewing this letter to continue your support for these organizations and the good they doefor our citizens and the community as a whole.

Sincerely

Herbert T. Wright, Jr.

**Department of Psychiatry**
**Psychiatric Research Institute**
4301 W Markham St. #554
Little Rock, AR 72205-7199
MAIN 501-526-8169
FAX: 501-526-8199

psychiatry.uams.edu

UAMS
University of Arkansas for Medical Sciences

**G. Richard Smith, M.D.**
Marie Wilson Howells Professor
Chairman, Department of Psychiatry
Director, Psychiatric Research Institute
smithgrichard@uams.edu

March 13, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

To Whom It May Concern:

I am writing this letter to recommend **Centers for Youth and Families (The Centers)** in conjunction **Little Rock Community Mental Health Center's (LRCMHC)** response to bid number 710-19-1024, Crisis and Forensic Mental Health Services. The Centers and LRCMHC are uniquely qualified to provide community behavioral health services for persons in Region 6 of Arkansas considered indigent and identified as experiencing a serious mental illness or other serious behavioral disorder. I understand this proposal will provide support for those services now provided by The Centers and LRCMHC to continue uninterrupted.

As the child and adolescent affiliate of the LRCMHC, The Centers has extensive experience providing a well-coordinated array of programming and treatment services and is committed to keeping children, youth and families within the community and out of emergency rooms for acute care, psychiatric hospitals and psychiatric residential treatment centers. At the same time, LRCMHC has extensive experience providing an array of early intervention and recovery focused therapeutic interventions and supports to adults with severe psychiatric disorders and other serious behavioral problems. Together, these two agencies have the demonstrated capacity to carry out the services set forth in the RFQ, and this proposal builds on that demonstrated capacity in further strengthening this collaborative continuum.

As Chairman of the Department of Psychiatry in the College of Medicine at UAMS, I can directly attest to The Centers and LRCMHC's commitment to trauma-informed, person-centered treatment for adults with SMI and children and youth with SED. I have no hesitation that their commitment to a No Wrong Door System of care will yield significant improvements to the structure and services for individuals with significant behavioral illness in our community.

Finally, UAMS is both excited and encouraged by The Centers and LRCMHC's initiative to carry out innovative, comprehensive and community-based services for clients with significant behavioral health needs. Their coordinated care and treatment in the community will ensure vulnerable populations, predominantly those without insurance, the underinsured and ASH-related client's unique personal needs are met. Should you need further information, I can be reached at smithgrichard@uams.edu or 501-526-8169.

Sincerely,

G. Richard Smith, M.D.

**MELANIE H. MARTIN**
District Court Judge
600 West Markham
Little Rock, AR 72201

Little Rock District Court
First Division
Pulaski County

Phone: (501) 371-4739
Fax: (501) 371-4515
www.lrcriminal.gov

March 11, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

RE: Bid Number: 710-19-1024

To Whom It May Concern:

The Little Rock District Court-1st Division Criminal fully supports the re-application by Little Rock Community Mental Health and Centers for Youth and Families' DAABHS CMHC Grant. This comprehensive strategy aims at system level reductions in the prevalence of mental illness and substance abuse in the City of Little Rock and Pulaski County. The goal is to engage in a collaborative planning process with local leadership working towards the goal of reducing the number of individuals with mental disorders and co-occurring substance abuse disorders that can be safely supervised and/or treated in our community.

Little Rock District Court-1st Division Criminal is fully committed to continuing to participate in this process by providing a framework/guidance in the local justice system and discussing solutions to decreasing the mental illness population. This Court recognizes the benefits of treatment programs and diversion and is happy to discuss alternatives and resources.

Sincerely,

Melanie H. Martin
Little Rock District Court Judge-1st Div. Criminal

# JEFFERSON COMPREHENSIVE CARE SYSTEM, INC.

P.O. Box 1285 • Pine Bluff, AR 71613-1285 • (870) 543-2380
www.jccsi.org

☐ Pine Bluff Medical & Dental Center
1101 Tennessee St.
P.O. Box 1285
Pine Bluff, AR
71613-1285
Phone: 870-543-2380
Dental: 870-543-2341
Fax: 870-535-4716

☐ Altheimer Center
309 S. Edline
P.O. Box 37
Altheimer, AR
72004
Phone: 870-766-8411
Fax: 870-766-8412

☐ Redfield Center
823 River Road
P.O. Box 66
Redfield, AR
72132-0066
Phone: 501-397-2261
Fax: 501-397-2263

☐ College Station Ctr.
4206 Frazier Pike
P.O. Box 668
College Station, AR
72053
Phone: 501-490-2440
Fax: 501-490-0156

☐ Open Hands Center
Healthcare for the Homeless
3000 Springer Blvd.
Ste. B
Little Rock, AR
72206
Phone: 501-244-2121
Fax: 501-244-2130

☐ Little Rock Community Health Center
1100 N. University
Ste. 125
Little Rock, AR 72207
Phone: 501-663-0055
Fax: 501-280-0602

☐ North Little Rock Community Health Ctr.
2525 Willow St.
Ste. 1
North Little Rock, AR
72114
Phone: 501-812-0225
Fax: 501-812-0284


February 27, 2019

Thomas A Grunden
Executive Director
Little Rock Community Mental Health Center
1100 N. University, Suite 201
Little Rock, Arkansas 72207

Dear Mr. Grunden,

On behalf of Jefferson Comprehensive Care System, Inc. (JCCSI), I am pleased to provide Little Rock Community Mental Health Center(LRCMHC) with a letter of support for it grant application for mental healthcare funding. LRCMHC has been a vital component in providing mental healthcare services to indigent persons in our community. JCCSI feels very strong that LRCMHC will continue to provide these services which is so desperately needed in our community.

JCCSI has a long history with LRCMHC especially with meeting the needs of the homeless population we serve. Many of the patients LRCMHC serves need primary care and we have been available to meet those needs. In addition, LRCMHC has met the needs of many of the primary care patients we serve. We continue to explore opportunities for collaboration in meeting the needs of some of the most vulnerable patients in our community.

JCCSI is honored to support LRCMHC application for mental health funding. We look forward to working together for many years to come to serve individuals in our area who desperately need high quality mental healthcare services.

Sincerely,

Sandra J. Brown, MPH, MSN, RN
Chief Executive Officer

**City of Little Rock**

City Hall, Room 203
500 W. Markham
Little Rock, Arkansas 72201-1427
Phone: (501) 371-4510
Fax: (501) 371-4498
www.littlerock.gov

March 14, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

RE: CMHC RFQP Proposal to DHS/DAABHS to Provide Behavioral Health Services in Little Rock and South Pulaski County

To Whom It May Concern:

I am writing to indicate my support for this referenced proposal submitted by Centers for Youth and Families in conjunction with Little Rock Community Mental Health Center to provide community behavioral health services for persons considered indigent and identified as experiencing a serious mental illness or other serious behavioral disorders.

As Mayor of Little Rock, I am keenly aware of the need for community mental health services for our community, especially for homeless individuals and families. Mental illness and homelessness are intertwined, as many homeless persons suffer from one or more mental health diagnoses.

Little Rock Community Mental Health Center has provided a broad range of mental health outpatient treatment services to citizens of our community for over 50 years. During that time, LRCMHC has built strong relationships with other community providers, creating a network dedicated to community mental health and reduction of homelessness. Permanent housing provided by LRCMHC has safe and secure living accommodations for homeless persons and families for many years, providing them with an alternative to emergency shelters and living in places not meant for human habitation.

I support the continued funding and other support provided to these agencies and the important work carried out by them in the Greater Little Rock area.

Sincerely,

Frank Scott, Jr.
Mayor

DEPAUL
Homelessness has no place
3000 Springer Blvd
Little Rock, AR 72206
501-916-9859

March 12, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

RE: CMHC RFQP Proposal to DHS/DAABHS to Provide Behavioral Health Services in Little Rock and South Pulaski County

To Whom It May Concern:

I am writing to indicate my support for this referenced proposal submitted by Centers for Youth and Families in conjunction with Little Rock Community Mental Health Center to provide community behavioral health services for persons considered indigent and identified as experiencing a serious mental illness or other serious behavioral disorders.

Jericho Way has a long-standing relationship with Little Rock Community Mental Health Center (LRCMHC) as a referral resource for individuals and families needing mental health services as part of Jericho Way's network of providers. Beyond this important resource role, LRCMHC has a long-standing relationship with Jericho Way in extending important supportive resources to those homeless individuals and families receiving on-site services.

From the initial planning regarding the Day Resource Center until now, LRCMHC has provided on-site outreach and assessment, as well as, tangible supports, access to transportation clothing, food, move-in deposits, medications, eviction arbitration and entitlement eligibility through LRCMHC's SOAR Program

I support the continued funding and other support provided to these agencies and the important work carried out by them in the Greater Little Rock area.

Sincerely,

Amanda Nardi Davis

CATCH
Central Arkansas Team Care for the Homeless

500 West Markham, Suite 120 West
Little Rock, Arkansas 72201
Phone: 501-371-4439, Fax: 501-399-3461

March 12, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

RE: CMHC RFQP Proposal to DHS/DAABHS to Provide Behavioral Health Services in Little Rock and South Pulaski County

To Whom It May Concern:

I am writing to indicate my support for this referenced proposal submitted by Centers for Youth and Families in conjunction with Little Rock Community Mental Health Center (LRCMHC) to provide community behavioral health services for persons considered indigent and identified as experiencing a serious mental illness or other serious behavioral disorders.

LRCMHC has been active in developing housing for persons with special needs since 1993, when it opened a sixteen (16) bed transitional program on S. Battery Street for men. Shortly thereafter, LRCMHC received 24 scattered housing units for the Kathleen Peek Apartments. During this same period, LRCMHC, along with other providers, established Central Arkansas Team Care for the Homeless (CATCH), a network of providers committed to reducing homelessness in the Central Arkansas four county area.

CATCH has been awarded numerous grants from HUD to provide permanent housing to homeless individuals and families in Central Arkansas. LRCMHC administers five (5) of these housing grants, allowing homeless individuals and families to move from emergency shelters to permanent housing. Permanent housing has been proven to be the major factor in preventing returns to homelessness. Over 400 persons are presently housed under the grants administered by LRCMHC, significantly contributing to their achieving maximum recovery from their mental health diagnoses.

I support the continued funding and other support provided to these agencies and the important work carried out by them in the Greater Little Rock area.

Sincerely,

Fredrick Love,
Board President
Central Arkansas Team Care for the Homeless

BCD, Inc.
Better Community Development, Inc.

Rebuilding Lives. Restoring Communities.

March 12, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

RE: CMHC RFQP Proposal to DHS/DAABHS to Provide Behavioral Health Services in Little Rock and South Pulaski County

To Whom It May Concern:

Better Community Development Inc. (BCD) I am writing to indicate our support for this referenced proposal submitted by Centers for Youth and Families in conjunction with Little Rock Community Mental Health Center to provide community behavioral health services for persons considered indigent and identified as experiencing a serious mental illness or other serious behavioral disorders.

LRCMHC and BCD have a long-standing history of mutual assistance. This includes referrals for substance abuse treatment and referrals for permanent housing. BCD is aware of the Recovery Focus and Psychiatric Rehabilitation and the importance that the ability to work and to have access to employment plays in gaining independence. LRCMHC has long provided many permanent housing options for homeless individuals and families, which BCD has frequently referred clients to.

We are familiar with the broad range of services offered by Little Rock Community Mental Health Center (LRCMHC). These services have had significance in numerous homeless individuals and families moving from emergency shelter through transitional housing into permanent housing. LRCMHC has demonstrated knowledge and support for this type of effort.

We support the continued funding and other support provided to these agencies and the important work carried out by them in the Greater Little Rock area.

Sincerely,

Director of Programs

3604 W. 12th Street • Little Rock, AR 72204 • Phone (501)663-7223 • Fax (501)663-7228 • www.bcdinc.org

OUR HOUSE

March 12, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

RE: CMHC RFQP Proposal to DHS/DAABHS to Provide Behavioral Health Services in Little Rock and South Pulaski County

To Whom It May Concern:

I am writing to indicate my support for this referenced proposal submitted by Centers for Youth and Families in conjunction with Little Rock Community Mental Health Center (LRCMHC) to provide community behavioral health services for persons considered indigent and identified as experiencing a serious mental illness or other serious behavioral disorders.

LRCMHC provided on-site services at Our House for many years. Our House is aware of the Recovery Focus and Psychiatric Rehabilitation at LRCMHC and the importance of the ability to work and to have access to employment in gaining independence. Our House is willing to accept referrals for basic living skill development, as well as employment related services.

I am familiar with the broad range of services offered by Little Rock Community Mental Health Center (LRCMHC). For a number of years, LRMCHC has provided a range of Permanent Housing opportunities for not only Our House, but, also for clients of other agencies in the local Continuum of Care area. These services have had significance in numerous homeless individuals and families moving from emergency shelter through transitional housing into permanent housing. LRCMHC has demonstrated knowledge and support for this type of effort.

I support the continued funding and other support provided to these agencies and the important work carried out by them in the Greater Little Rock area.

Sincerely,

Ben Goodwin
Executive Director

children's protection center
1210 wolfe street
little rock, AR 72202

(501) 364-5490

childrensprotectioncenter.org

March 11, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

Re: Bid Number: 710-19-1024

To Whom It May Concern:

Children's Protection Center (CPC) is pleased to support Centers for Youth and Families (The Centers) response to solicitation number 710-19-1024, Crisis and Forensic Mental Health Services. The Centers is uniquely qualified to carry out the array of services set forth in the RFQ including coordinating community-based support programs for individuals with significant behavioral health needs in Region 6 of Arkansas. CPC shares in this mission in that we provide individualized advocacy services that aid children and families in recovering from complex mental health problems associated with trauma.

As Executive Director of CPC, I can directly attest to The Centers' Recovery-Oriented Model of Treatment through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential. At CPC, we recognize that without effective therapeutic intervention, many child victims of abuse will suffer on-going or long-term consequences. Our team's response to allegations of abuse include access to trauma assessments, crisis intervention and specialized medical interventions. Therapy services are offered to families internally at CPC or through scheduled appointments with other community mental health providers, including The Centers.

The Centers has a long and successful history of working effectively with many community partners, including CPC. We support The Centers in continuing to work with all necessary stakeholders to ensure that vulnerable populations unique personal needs are met. I believe The Centers approach to coordinated, person-centered care will yield significant improvements to the structure and services for individuals with significant behavioral illness in our community. We welcome the opportunity to participate in this system and look forward to increasing our ability to provide effective treatment for individuals with SMI and SED. Should you need further information, I can be reached at jlong@childrensprotectioncenter.org or 501-364-5490.

Jennifer Long,
Executive Director
Children's Protection Center

# Attachment B

# Resumes

# Melissa Dawson

9 Augusta Drive
Maumelle, AR. 72113
501-350-8799
mdawson@cfyf.org

---

**CENTERS FOR YOUTH AND FAMILIES**
Chief Executive Officer, December 2017-Present

- Oversee preparation of annual budget
- Oversee and monitor financial and clinical key indicators for each program
- Develop and implement new programs

Chief Operating Officer, October 2005 – December 2017

- Directly supervise all administrative departments as well as, Little Rock Residential, Monticello Residential and Therapeutic Foster Care Programs
- Maintain utmost discretion when dealing with sensitive topics

Director of Human Resources, September 1997-October 2005

- Responsible for the overall planning, organizing and implementing the Human Resources functions of the agency
- Developed and administered Human Resources policies and procedures
- Secured benefits with employment benefit agencies
- Provided direction and feedback to managers regarding needs, improvements and accomplishments
- Ensured compliance with appropriate laws and licensing regulations
- Responsible for coordination of activities to improve employee morale and the coordination of the Employee Assistance Program

Assistant Director of Human Resources, May 1996-Septermber 1997

- Provided assistance to managers with employee issues and policies
- Designed and created Human Resources database that is still in use today
- Assisted managers with hiring, disciplinary procedures and terminations
- Developed and administered Human Resources policies and procedures
- Identified sources, developed and maintained contacts for recruiting applicants

Employment Coordinator, November 1995-May 1996

- Managed the recruitment and interviewing process for the organization
- Conducted interviews and made selections for open positions
- Checked references on new hires and potential new hires

Administrative Assistant-Human Resources, April 1995-November 1995

- Functioned as the receptionist for Human Resources Department
- Developed and created Job Descriptions with input from managers
- Maintained Human Resources Files
- Preformed Payroll when Payroll Coordinator was absent

**YOUTH HOME**
Residential Treatment Counselor, June 1993-November 1994

- Ensured the health, safety and welfare of adolescents
- Intervened in crisis situations by using de-escalation skills while keeping the child and environment safe
- Helped the client learn positive communication and social skills

**MOVIELAND**
Store Manager, September 1987-September 1992

- Supervised employees
- Managed customer services, accounts payable, accounts receivable, payroll and store budget

## EDUCATION

**UNIVERSITY OF ARKANSAS AT LITTLE ROCK**
*Bachelor of Arts in History, December 1992*
*Bachelor of Arts in Criminal Justice, December 1992*
*Master of Public Administration, December 2000*

# David Kuchinski, LCSW

3711 Robinwood Circle, Bryant, Arkansas 72022
501-425-0126
dskuchinski@sbcglobal.net


## Licensure

| | | | |
|---|---|---|---|
| LCSW | Arkansas License | No. 1177-C | Expiration Date 2/28/2016 |
| | Florida License | No. SW 12335 | Expiration Date 3/31/2017 |

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I have twenty years of clinical and management experience, nurturing a Recovery milieu, fostering a person-centered treatment continuum serving adults with serious and persistent mental illness. I believe in the power of relationships for positive change as a foundation to develop and maintain a therapeutic community.

## Accomplishments

- Transformed the organization treatment model from Medical model to a Recovery-oriented, person-centered treatment model.
- Implemented person-centered treatment planning, integrated evidenced-based practices, established clinically based prescriptions and a service tracking practice that facilitated measurable outcomes.
- Nurtured high standards for quarterly clinical outcomes for treatment plan goal achievement, medication independence, consumer satisfaction and community integration.
- Assisted in earning multiple 3 year CARF accreditations and multiple commendations for Recovery milieu and Quality Assurance practices.
- Developed a simplified documentation process to maximize the skill set of Mental Health Paraprofessionals to meet RSPMI standards and satisfied manage care audits yielding 98% prior authorization approval and minimal audit deficiencies.
- Participated on multiple work groups with DHS, DBHS, Medicaid, Value Options and Mental Health Council to develop a new community-based, recovery-oriented system of care for the State.
- Wrote the criteria for the State's Act 911 Early Release program, served on the Act 911 Early Release Committee.

## Professional Experience

**Centers For Youth and Families**
**Chief Clinical Officer July 2018-present**

- Provide clinical oversight for Residential, Outpatient, Therapeutic Foster Care, and Crisis Services.
- Supervises Utilization Management and Performance Improvement Committees.
- Training and supervising transition to Trauma Informed Care and Person-centered treatment milieu.
- Coordinating specialized Human Trafficking program.

**Birch Tree Communities, Inc.**
**Chief Operating Officer January 2011-July 2018**

**RESUME**
**CURRICULUM VITAE**
**Zarina Shah, M.D.**

***CURRENT POSITION***:

7/95 - Current — Medical Director
CENTERS FOR YOUTH AND FAMILIES
PO Box 251970
Little Rock, Arkansas 72225-1970

***PROFESSIONAL EXPERIENCE/ACADEMIC POSITIONS***:

7/95 - Current — Medical Director
CENTERS FOR YOUTH AND FAMILIES
PO Box 25190
Little Rock, AR 72225-1970

7/94 - 6/95 — Associate Medical Director
CENTERS FOR YOUTH AND FAMILIES
PO Box 25190
Little Rock, Arkansas 72225-1970

3/93 - 6/94 — Vice-Chief
Division of Child and Adolescent Psychiatry
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Little Rock, Arkansas 72205

9/90 - 6/94 — Medical Director, Turning Point Adolescent
ARKANSAS CHILDREN'S HOSPITAL
Little Rock, Arkansas 72202

***Professional Experience/Academic Positions*** (continued):

9/90 - 6/94 — Assistant Professor,
Department of Psychiatry
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Little Rock, Arkansas 72205

9/88 - 8/90 — Unit Director, Adolescent Program
SOUTHEAST LOUISIANA HOSPITAL
Mandeville, Louisiana

8/81 - 6/91 — Clinical Assistant Professor,
Department of Pediatrics
TULANE UNIVERSITY SCHOOL OF MEDICINE
New Orleans, Louisiana

8/81 - 3/82 — Assistant Professor, Department of Psychiatry
TULANE UNIVERSITY SCHOOL OF MEDICINE
New Orleans, Louisiana

9/79 - 7/81 — Staff Psychiatrist, Adolescent Unit
SOUTHEAST LOUISIANA HOSPITAL
Mandeville, Louisiana

***EDUCATION***:

| | |
|---|---|
| 7/78 - 6/79 | Fellow, Child and Adolescent Psychiatry<br>MAYO CLINIC, Rochester, Minnesota |
| 7/76 - 6/78 | Fellow, Child and Adolescent Psychiatry<br>CHILDREN'S PSYCHIATRIC HOSPITAL,<br>UNIVERSITY OF MICHIGAN<br>Ann Arbor, Michigan |
| 7/73 - 6/76 | Resident, Adult Psychiatry<br>NORTHVILLE STATE HOSPITAL |
| 7/71 - 6/72 | Resident, Internal Medicine (6 months<br>Internal Medicine, 6 months Neurology)<br>JJ GROUP OF HOSPITALS<br>University of Bombay, India |
| 7/70 - 6/71 | Internship<br>JJ GROUP HOSPITALS<br>University of Bombay, India |
| 1965 - 1970 | M.B.B.S. (equivalent to M.D. in USA)<br>GRANT MEDICAL COLLEGE<br>University of Bombay, India |
| 1963 - 1965 | InterScience (Pre-Medical) (equivalent to<br>baccalaureate degree in USA)<br>ELPHINSTONE COLLEGE<br>University of Bombay, India |

***ACADEMIC RESPONSIBILITIES***:

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Department of Psychiatry
Little Rock, Arkansas 72205

| | |
|---|---|
| 7/92 - 6/93 | Chairperson, Grand Rounds Committee |
| 7/91 - 6/94 | Director, Child/Adolescent Core Curriculum<br>(for Fellows, Residents, Medical Students) |
| 9/90 - 6/94 | Lecturer, Junior Clerkship in Psychiatry<br>Preceptor to two Junior Medical Students<br>Supervisor/Teacher: 1-2 Child Fellows<br>2 General Psychiatry Residents<br>1-2 Medical Students |
| 9/90 - 6/94 | ARKANSAS CHILDREN'S HOSPITAL<br>Turning Point Adolescent Psychiatric<br>Inpatient Unit<br>Little Rock, Arkansas 72202 |

***LICENSURES AND CERTIFICATION***:

| | |
|---|---|
| 1973 | ECFMG |
| 1975 | FLEX |
| 1990 - Current | Arkansas State Medical Board |

***BOARD APPOINTMENTS***:

10/92 - 6/97 Member, Social Work Licensing Board,
State of Arkansas
Secretary, Social Work Licensing Board,
State of Arkansas

***LOCAL COMMITTEES***:

7/94 - Current Member, Senior Management Team
Staff Member, Centers Board Committee
Staff Member, Operations Committee of the
Centers Board of Directors
Chair, Medical Management Committee
Member Utilization Management Committee
Member Performance Improvement Committee
Member Client Records Committee CENTERS FOR
YOUTH AND FAMILIES
Little Rock, Arkansas 72205

1990 - 6/94 Member, Child Residency Education Committee
Department of Psychiatry
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Little Rock, Arkansas 72205

1990 - 1991 Member, Chairman's Junior Faculty Development
Committee, Department of Psychiatry
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Little Rock, Arkansas 72205

7/92 - 6/93 Chairperson, Grand Rounds Committee
Department of Psychiatry
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Little Rock, Arkansas 72205

6/93 - 6/94 Member, Steering/Operations Committee
Department of Psychiatry
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
Little Rock, Arkansas 72205

***PROFESSIONAL SOCIETY MEMBERSHIPS***

*American Academy of Child and Adolescent Psychiatry*

***PRESENTATIONS/PUBLICATIONS***:

"ADOLESCENT PANIC SYMPTOMS AND SUICIDAL BEHAVIOR" John B. Jolly, Psy.D., Richard Livingston, M.D., Zarina Shah, M.D., David McCray, M.D., and Janet Jolly. Poster presented at the 146th Annual Meeting of the American Psychiatric Association in San Francisco, May, 1993.

Livingston, R., M.D., Shah, Z., M.D., Wells, A., LCSW. Letter to the Editor: "HOMICIDE DEATHS OF RECENTLY HOSPITALIZED ADOLESCENTS." Journal of the American Academy of Child and 0000Adolescent Psychiatry. July, 1994.

- Provide clinical oversight to a residential/outpatient recovery-oriented program serving 440 adults with serious and persistent mental illness.
- Supervise branch operations for 12 branches across the state, assist in managing $25 million budget.
- Serve on the Executive Team to assist in operationalizing the company mission and assist in supervising administration staff.
- Promote Recovery through Branch Leadership meetings, developing and implementing clinical policy and monitoring through peer review oversight.
- Promote strength-based staff and leadership development to 30+ Mental Health Professionals and 400+ Mental Health Paraprofessionals.
- Monitor multiple external audit processes, working proactively with manage care entity, adjusting clinical practice and documentation practices to achieve minimal audit deficiencies.
- Maintain positive working relationship with DHS, DBHS, Arkansas Medicaid, Value Options (managed care), Arkansas Mental Health Council and the Arkansas State Hospital.
- Assist in planning and implementation of CARF standards.
- Serve on the Quality Assurance and Admissions Committees.
- Spearhead and implement strategic planning.

**Clinical Director January 2006-January 2011**

- Coordinated and supervised clinical operations for 12 branches serving 450 adults.
- Served on Executive Team contributing to oversight and direction for branch operations.
- Developed and implemented policies and practices balancing Recovery principles, RSPMI, DD, CARF and managed care standards.
- Achieved a high percentage of prior authorization approval.
- Modeled a specialized staffing process for medically complex individuals.
- Chaired the Quality Assurance Committee and coordinated admissions.
- Developed current chart review tool for Peer Review.
- Assisted in implementation of EHR.

**Branch Clinical Director June 1995-December 2005**

- Provided clinical supervision to an interdisciplinary team at the AHC Branch, which is the original branch and served acute individuals.
- Transformed the treatment approach to a person-centered, strengths-oriented philosophy.
- Supervised and directed medically complex staffing and treatment outcomes.

**Crisis House Director January 1995-May 1995**

- Coordinated operations for a 15-bed crisis unit, providing clinical and administrative oversight to an interdisciplinary team and coordinated referrals from area mental health centers.

**Site Coordinator/Primary Therapist May 1994-December 1995**

- Provided treatment planning, case coordination, individual and group therapy to adults with serious mental illness.
- Provided clinical supervision and administrative oversight to 45 consumers, 3 Mental Health Professional and 30 Mental Health Paraprofessionals.

**Centers for Youth and Families Adolescent Day Treatment Program**
**Primary Therapist August 1993-May 1994**

- Served a caseload of 20 at-risk teenage students in a therapeutic alternative school setting, providing treatment planning, case coordination, individual and group therapy.

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## Education

University of Arkansas at Little Rock-Little Rock, Arkansas
Master of Social Work; May 1993

University of Arkansas, Fayetteville, Arkansas

B.A. Psychology; May 1990

# Thomas A. Grunden

2001 South Arch Street
Little Rock, Arkansas 72206
Phone: (501) 372-5546 Email: tagrunden@aol.com

**EDUCATION:**

M.S.W. – George Warren Brown School of Social Work
Washington University, St. Louis, Missouri
Spring, 1967

B.S. – Southern State College, Magnolia, Arkansas
Fall, 1963

**CERTIFICATION:**

Academy of Certified Social Workers
1969 – 1982

National Registry of Clinical Social Workers
1967 – 1982

State of Arkansas Social Work Licensing Board
1982 – 2003

**AREAS OF INTEREST**

**National Public Policy for Mental Health Services**
Management of Human Service Delivery Systems
Psychiatric Rehabilitation for Persons with Serious and Persistent Mental Illness
Mental Health Financial Reimbursement Systems
Partial Hospitalization – Program Management

**PROFESSIONAL WORK HISTORY**

**Little Rock Community Mental Health Center, Inc.**
**Little Rock, Arkansas**
Executive Director
1986 – Present

*Program expansion during tenure – 2.0 million dollars to 4.7 million dollars; staff from 45 to 150*

**Arkansas Division of Mental Health Services**
**Little Rock, Arkansas**
Associate Director of Community Services
Assistant Commissioner of Long Term Care and Community Services
1983 – 1986

*Established Medicaid Prior Authorization System – Increased Medicaid funding Mental Health System from 1.2 million dollars to current 30.0 million dollars*

**Benton Services Center**
**Benton, Arkansas**
Director
Project Director – 14.0 Million Dollars Construction Project
1981 – 1983

**Community Mental Health Center, Inc.**
**Lawrenceberg, Indiana**
Executive Director
1980 – 1981

*Five-county mental health center – 2.8 million budget; 5 service sites; 36-bed patient unit; 80 employees*

**Delta Counseling & Guidance Center, Inc.**
**Monticello, Arkansas**
Executive Director
1970 – 1980

*Five-county multi-service agency – 2.1 million budget; 7 service sites; 105 employees; 1.5 million dollars construction projects*

**East Arkansas Regional Mental health Center**
**Helena, Arkansas**
Coordinator of Services
1970 – 1972

*Implemented Day Treatment and Inpatient Services; developed state's first multi-county juvenile court system; 1.2 million dollars program; 7 counties*

**South Arkansas Mental Health Center**
**Camden, Arkansas**
Coordinator of Camden Clinic; Coordinator of Work Activity Program; Clinical Social Worker
1967 – 1970

# Attachment C

# MOUs

# MEMORANDUM OF AGRREEMENT

This Memorandum of Agreement is made on 2/21/19 by and between Birch Tree Communities, Inc., 1781 Old Hot Springs Highway, Benton, Arkansas, 72018, and Centers for Youth and Families, P.O. Box 25190 Little Rock, AR 72225. The parties hereby bind themselves to undertake a Memorandum of Agreement ("Agreement") under the following terms and conditions:

**TERM.** The term of this Agreement shall be one year unless terminated sooner in accordance with the terms of the Agreement (the "Term").

**GOALS AND OBJECTIVES.** Centers for Youth and Families, Inc. is enlisting the help of Birch Tree Communities, Inc. to provide "Therapeutic Community" services for Adult clients with a Serious Mental Illness as defined by the Arkansas Department of Behavioral Health in the state contract with Community Mental Health Centers. The parties of this agreement shall abide by the terms of this agreement to achieve the following goals and objectives:

## OBLIGATIONS OF THE PARTIES.

Birch Tree Communities, Inc., shall perform the following obligations:

The process for evaluation will be established between each CMHC and TC provider, specifying the medium of exchange, the form of notification of unsuitability, and individuals to be notified. The response time to notification of unsuitability by a provider shall be no later than forty-eight hours. If the response time is longer then the provider may begin billing at 1.5 times the billing rate after the forty-eight hour period.

Centers for Youth and Families, Inc., shall perform the following obligations:

Pre-Tiering Requirements

Prior to the acceptance of a member by a licensed Therapeutic Communities provider ("provider" or "TC Provider") the member must be appropriately tiered as either Level 1 or Level 2 ("TC 1" and "TC 2") as defined in the Arkansas Department of Human Services Therapeutic Communities Certification Manual or the equivalent of a TC 1 or TC 2 member as outlined by any of the Arkansas Provider-Led Shared Savings Entities ("PASSEs").

If a referred member has not been tiered, then providers have the option to deny admission into a TC 1 or TC 2 program until the member has been tiered. Alternatively, the referring Community Mental Health Center ("CMHC") may offer to reimburse the TC provider for the days not tiered until the date of tier at the rate determined by the DHS or PASSE billing manuals for the appropriate level of care. This agreement shall be in writing. The TC provider has the right to deny this request.

Evaluation Term

A provider is granted an evaluation term of thirty days in which the provider may determine whether a member is an appropriate fit for the Therapeutic Communities ("TC") program. A provider also has the right to deny acceptance of a member, tiered or non-tiered, without a thirty-day evaluation. If a member has been accepted by a TC program and deemed unsuitable then the referring CMHC must

re-admit the member or make plans to admit the member to a new program no later than seven calendar days after the thirty-day evaluation term ends.

The TC provider shall be reimbursed for each day during the evaluation term at the rate determined by the DHS or PASSE billing manuals for the appropriate level of care. If a member is still in the care of a TC program after the thirty-day evaluation period and the member has been deemed unsuitable then the TC provider may bill at 1.5 times the billing rate so long as the member remains under the provider's care.

Medicaid Eligibility Status

A TC provider may deny a referral of a member that has no Medicaid, Medicare or private health insurance coverage. A TC provider also has the option to deny a member if the member is in the Medicaid Spend Down program. Alternatively, if the provider accepts a Spend Down member then the CMHC must reimburse the TC provider for services performed by the TC provider that must be delivered to activate Medicaid for that member.

These "uncovered services" required to activate Medicaid are recurring and vary based on the member's income. Once the amount of uncovered services meets the Medicaid threshold that activates coverage, that member will have a window of active Medicaid coverage for three months. After this period then the coverage expires and the member must again meet the threshold to activate Medicaid coverage. As long as the member is under the provider's care and is not referred back to a CMHC then the provider will continue to be reimbursed for uncovered services by the CMHC.

**CONFIDENTIALITY.** Subject to sub-clause (2) below, each party shall treat as strictly confidential all information received or obtained as a result of entering into or performing this Agreement.

Each party may disclose information which would otherwise be confidential if and to the extent:

(i) required by the law of any relevant jurisdiction;
(ii) the information has come into the public domain through no fault of the party; or
(iii) the other party has given prior written approval to the disclosure, provided that any such information disclosed shall be disclosed only after consultation with and notice to the other party.

**REPRESENTATIONS AND WARRANTIES.** Each party to this Agreement represents and warrants to the other party that it:

(a) has full power, authority, and legal right to execute and perform this Agreement;
(b) has taken all necessary legal and corporate action to authorize the execution and performance of this Agreement.

**MEMORANDUM OF AGREEMENT SUMMARIZATION.**

Furthermore, the parties to this Agreement have mutually acknowledged and agreed to the following:

- The parties to this Agreement shall work together in a cooperative and coordinated effort, and in such in manner and fashion to bring about the achievement and fulfillment of the goals and objectives of this partnership.
- It is not the intent of this Agreement to restrict the parties to this agreement from their involvement or participation with any other public or private individuals, agencies or organizations.
- The parties to this Agreement shall mutually contribute and take part in any and all phases of the planning and development of this partnership, to the fullest extent possible.
- It is the intent or purpose of this Agreement to create any rights, benefits and/or trust responsibilities by or between the parties.
- The Agreement shall in no way hold or obligate either party to supply or transfer funds to maintain and/or sustain the partnership
- Should there be any need or cause for the reimbursement or the contribution of any funds to or in support of the partnership, it shall then be controlled in accordance with Arkansas governing laws, regulations and/or procedures.
- In the event that contributed funds should become necessary, any such endeavor shall be outlined in a separate and mutually agreed upon written agreement by the parties or representatives of the parties in accordance with current governing laws and regulations, and in no way does this Agreement provide such right or authority.
- The Parties to this Agreement have the right to individually or jointly terminate their participation in this Agreement provided that advanced written notice is delivered to the other party.
- Upon the signing of this Agreement by both parties, this Agreement shall be in full force and effect.

**AUTHORIZATION AND EXECUTION.**

The signing of this Memorandum of Agreement does not constitutes a formal undertaking, and as such it simply intends that the signatories shall strive to reach, to the best of their abilities, the goals and objectives stated in this MOU.

This agreement shall be signed by Birch Tree Communities, Inc., and Centers for Youth and Families, Inc, and shall be effective as of the date first written above.

2/24/19

First Party Signature — Date

Birch Tree Communities, Inc.

Melina Dawson — 3/14/19

Second Party Signature — Date

Centers for Youth and Families

# Memorandum of Agreement Between Centers for Youth and Families and Ouachita Behavioral Health and Wellness

WHEREAS, Centers for Youth and Families, Inc. (CYF) is a non-profit community mental health center serving persons with mental illness in Central Arkansas; and

WHEREAS, Ouachita Behavioral Health and Wellness (Provider) is also a non-profit community mental health center serving persons with mental illness in Central Arkansas; and

WHEREAS, both entities have similar interests in meeting the needs of Arkansas' citizens and wish to be able to utilize resources of each other;

NOW THEREFORE, both OBHAW and Provider agree to the following:

1. Each party is familiar with the services offered by the other party and shall exchange specific contact information in order for each party to make referrals to the other party.
2. CYF shall, where appropriate, refer individuals to Provider as needed for the service of Partial Hospitalization.
3. This agreement does not create any on-going obligation, financial or otherwise, to the other party but merely creates a relationship for purposes of referrals.

AGREED, this the 5th day of March, 2019.

Melena Dawson
Melissa Dawson
Centers for Youth and Families

3/14/19
Date

Robert Gersh, Ph.D.
Robert Gershon, Ph.D., CEO
Ouachita Behavioral Health and Wellness

3/14/19
Date

**MEMORANDUM OF UNDERSTANDING**

March 11, 2019

Arkansas Department of Human Services
Division of Aging, Adult and Behavioral Health Services
700 Main Street, Slot W345
Little Rock, AR 72201

To Whom It May Concern:

This Memorandum of Understanding supports **Centers for Youth and Families' (CFYF)** response to bid number 710-19-1024 to serve as the Community Mental Health Center for Region 3 in Arkansas.

Recovery Centers of Arkansas (RCA), is a CARF accredited substance abuse treatment program operating in the Central Arkansas area that is licensed by the state of Arkansas for Behavioral Health and Substance Abuse Treatment and staffed by waivered psychiatrists (in conjunction with its Medication Assisted Treatment program), master's level social workers and licensed counselors, licensed alcohol and drug counselors, certified alcohol and drug counselors and trained peer recovery support specialists. As a partner in good faith, **RCA** will provide the following services for individuals referred by **CFYF** under the proposed contract:

- **Substance Abuse Residential Treatment:** Curriculum for residential treatment is a four-week cycle that includes models such as traditional 12-step work, family systems theory and cognitive behavioral therapy. Services include structured, intensive treatment seven days a week with a minimum of 33 hours of group therapy and one hour of individual therapy weekly.
- **Partial Hospitalization:** PHP is a middle ground between residential and outpatient care. Clients spend several hours each day participating in treatment and therapy.
- **Intensive Outpatient Services:** This level of treatment is often used as a step-down from residential treatment. A minimum of one individual and three group sessions per week for 4-6 weeks are provided.
- **Outpatient Services:** This level is often used by individuals active in self-support organizations such as Alcoholics Anonymous or Narcotics Anonymous or by individuals with other strong support systems. A minimum of one individual and two group sessions per week are provided.
- **Reentry Program:** RCA is licensed by Arkansas Community Corrections as a transitional facility for paroles and provides re-entry services to residents.
- **Chemical Free Living:** Chemical-free living space for adults progressing successfully in recovery. A 30-bed chemical-free living facility offers those individuals who need extended services for those in an early stage of recovery.

DATED this 11th day of March 2019.

By: Melissa Dawson
Melissa Dawson, President/CEO
Centers for Youth and Families

By: Carole Baxter
Carole Baxter, Executive Director
Recovery Centers of Arkansas

RECOVERY CENTERS OF ARKANSAS

Carole Baxter, *Executive Director*

**Board of Directors**

George Bryant
Isadore Caldwell
Ralph Cloar
Dr. Geoff Curran
James Dietz
Amy Enderlin
Pete Hornibrook
Jim Julian
Andrew Kumpuris
Nancy Kumpuris
Thomas McCain
Dr. Larry Miller
Virginia Redden
J.D. Simpson, III
Lee Stephens

**Riverbend**
1201 River Road
North Little Rock, AR 72114

**Williamsburg**
6301 Father Tribou
Little Rock, AR 72205

**Steeplechase Apartments**
6225 Father Tribou
Little Rock, AR 72205

**Oasis Renewal Center**
14913 Cooper Orbit Road
Little Rock, AR 72225

# Attachment D

# Policies and Procedures

**CENTERS FOR YOUTH AND FAMILIES**

| Policy/Number | Chapter 27 | Emergency Services | |
|---|---|---|---|
| | | | |
| Effective Date | August 2017 | | |
| Expiration Date | August 2019 | | |
| | This policy is reviewed every 2 years. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Chief Clinical Officer | | |
| | Medical Director | | |
| | Operations Committee, Chair | | |

**POLICY:** Centers for Youth and Families provides prompt and appropriate services for all medical and psychiatric emergencies and responds to all after-hours emergency calls. When the nature of the emergency exceeds the medical/psychiatric capabilities of the agency, immediate referral is made to an appropriate facility.

**PURPOSE:** The purpose of this policy is to describe the way in which The Centers provides emergency services.

**PROCEDURES:**

I. Residential Treatment Programs

A. Medical Emergencies:

- The initial assessment of a medical emergency will be completed by the nurse on duty.
- Appropriate first aid/CPR will be instituted to stabilize the medical condition.
- The Program Manager, Medical Director and parent/guardian will be notified.
- An Incident Report is completed and set to Risk Management within 24 hours.

B. 911 Emergencies:

- If indicated, the nurse will call 911 ASAP.
- The nurse will then contact the appropriate physician/APRN or physician/APRN on call when the client is stable, or law enforcement arrives.
- The nurse will inform the Medical Director ASAP after the client is stable or law enforcement takes over.
- The nurse will complete an Incident Report and submit to Risk Management within 24 hours.
- If 911 is called, law enforcement will take over once they arrive, and staff will comply with law enforcement directives for further disposition of the client.
- The parent/guardian will be informed once the client is stable and or law enforcement has arrived.

C. Non 911 Emergencies:

- If the nurse determines a client needs to go to Emergency Room but may be transported by our staff, the nurse will contact the physician

or physician on call to discuss the situation, and obtain a physician order for further disposition. No client will be transported without discussing the emergency with the appropriate medical staff or physician on call.

- The nurse will contact the Medical Director within one hour of the emergency.
- The nurse will notify the appropriate physician or nurse of the receiving hospital regarding the nature of the emergency and information regarding the client's condition.
- The nurse will send appropriate medical authorization forms with the staff accompanying the client.
- The Program Manager will be notified.
- The parent/guardian will be notified as soon as possible.
- The MD will be notified upon the client's return from the hospital with details regarding disposition/ treatment. Discharge recommendations will be instituted by the physician or physician on call and nurse.

II. STEP

A. Assessment

1. Medical Emergency – Staff with first aid training/CPR will render first aid/CPR care to stabilize the client's condition and contact the EMAC nurse for further disposition. The nurse will reassess the client and call the medical staff on-call if needed for disposition. If the condition is life threatening, 911 will be called immediately; and the MD or MD on call will be notified when client is stabilized or after police/EMS takes over.
2. Psychiatric Emergency – Staff on duty will take appropriate measures to assure the safety of the client and contact the program manager/manager on call who will assess the need for further action. The clinician/clinician on call and physician/physician on call shall also be notified, documenting the action taken. Legal guardian shall be notified and must authorize or sign the client into the hospital facility if hospitalization is indicated.
3. Suicide Screening – Each new admission is screened for suicide risk. If the incoming client responds "yes" to any question on the screening, the emergency-on-call clinician is immediately notified and shall complete a face to face assessment of the client within one hour of receiving the call. Emergency Services will coordinate suicide screening after 5 pm and on weekends.

B. Implementation of Plan

Medical Emergency

1. The emergency room of the appropriate hospital will be alerted by the nurse that a client is en route and given information regarding the nature of the emergency.
2. Staff will make arrangements to transport either in an agency vehicle or by means of Emergency Medical Services. As a last resort if a personal vehicle has to be used, it is preferable that two persons transport. A decision to use EMS must be approved by the physician.
3. Staff will send appropriate medical authorization forms with the client and notify the parent/legal guardian of the emergency situation so that they may meet the staff and resident at the emergency facility. Discharge planning will be initiated with the treatment facility.
4. The staff involved in the emergency shall notify the Medical Director within one hour of the incident.

5. On return of the client to The Centers, the program manager will be informed of recommendations that will be instituted.

Psychiatric Emergency

1. Emergency Safety Interventions will be implemented if client is assessed to be in imminent danger to self or others.
2. Direct care staff will notify the manager-on call of the situation.
3. The emergency on call clinical staff will be called for consultation/assessment and their recommendation followed.
4. Legal guardian will be notified of the situation and will be responsible for signing for admission to acute if needed.

III. Outpatient and Day Treatment Service Areas

During regular working hours, active clients are the responsibility of their assigned clinician who will handle the emergency situation on or off site.

Non-clients needing inpatient hospitalization at Arkansas State Hospital and for whom DCFS is requesting a screening are managed by Centers Access clinicians. After hours, the emergency on-call clinician handles emergencies. A physician is also on call.

IV. Any program requiring the use of emergency transportation services may access it by calling 911 if the client's condition is too severe for agency vehicle transportation.

V. After Hours and Holiday Coverage

A. After 5 p.m. and on weekends and holidays, the Centers for Youth and Families main number rings to the CFYF professional answering service.
B. If an emergency, the professional answering service will transfer the call to the emergency cellular phone/qualified mental health professional.
C. The calling individual will be notified that a cellular phone is in use and there is limited expectation of privacy.
D. Numbers to Call
   1. Toll-free Access number: 1-888-868-0023
   2. Local number to Access: 501-666-8686
   3. The Centers for Youth and Families Emergency mobile phone number is 501-350-5702.
   4. Emergency administrative personnel are also available. The on call clinician has a list of back-up numbers.

VI. After Hours Emergencies

A. After 5 p.m. and on weekends and holidays, all emergencies, whether psychiatric or non-psychiatric in nature, must be reported to the Emergency Services staff on duty by calling either 666-8686 or 350-5702.
B. Incidents requiring notification to the on-call worker include
   1. Client/staff death or serious injury (where liability is concerned)
   2. Suicide attempt
   3. Client absent without leave (AWOL)
C. The on-call worker will notify appropriate management staff if the situation warrants it.
D. The reporting staff member is responsible for documenting the incident according to agency policy and routing it within the required time frame to Risk Management.
E. The emergency services on call clinician will log the call on the Inquiry Call Log.

F. The On Call Inquiry Log is submitted for signatures at the end of the of the on call week.

## Centers for Youth and Families

| Policy/Number | Chapter 50 | Physician on Call Policy | |
|---|---|---|---|
| | | | |
| Effective Date | July 2016 | | |
| Expiration Date | July 2017 | | |
| | This policy is reviewed annually. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Medical Director | | |
| | Chief Executive Officer | | |

**Purpose:** To provide after hours and week-end medical/psychiatric emergency services for Centers clients and continuity of care for Centers 24/7 programs.

**Procedure:** A Centers physician or nurse practitioner is on call after hours and on week-ends for Centers clinical programs.

Call duration is from 8:00 am on Monday to 8:00 am the following Monday.

A call schedule is prepared and circulated to the programs by the Medical Director in December for the following year.

Call weeks may be exchanged between medical staff if mutually agreed upon. The staff requesting the change will inform the programs and the Medical Director.

**On-call Functions:**

**Emergencies:**

- **Residential Programs:** The on-call physician is notified by the nurse in case of emergency after a nursing assessment. The physician performs an over the phone, medical or psychiatric assessment and directs the nurse in the next steps to be taken.
- **Shelter/TTLC programs:** The residential nurse will complete an assessment and contact the on call physician for further disposition.
- **TFHP, Day Treatment and Outpatient Services:** The emergency clinician will contact the medical staff on call in case medical/psychiatric input, assessment or other intervention is needed. If a client is sent to the hospital for acute care, the physician will be notified via phone or e-mail.

In case of a 911 emergency situation, the medical staff on call is notified after the client is in the charge of the paramedic staff. The Medical Director is also notified after the client leaves our facility and upon the client's return.

**Non emergency illness:** The nurse will assess and contact the medical staff if needed for treatment of the condition.

**Emergency Safety Interventions:** Orders for Emergency Safety Interventions will be signed by the physician.

**Continuity of Care:** Initiate or update Precautionary Status for clients based on nurse input.
The medical staff on call or nurse will inform the Medical Director in case of serious, unforeseen incidents.

**Documentation:** The nurse in the 24/7 programs and the emergency clinician for emergency services will document the nature of the emergency or service, assessment and treatment rendered in the client's EMR. Parents/guardians will be notified by the nurse regarding serious illness, psychiatric or medical emergency or in case an ESI was performed by the staff. The nurse will enter the orders in the EMR which will be signed by the physician in a timely manner.

**Timely Response by the On Call Physician**: The on call medical staff will respond ASAP when contacted by the nurse or the emergency on-call clinician. If there is no response with the first call, a second call will be made 15 minutes later. If there is still no response from the physician on call, the Medical Director or alternate medical staff will be called. The initial contact will be by phone and may be followed up by phone, email or text.

**CENTERS FOR YOUTH AND FAMILIES**

| Policy/Number | Chapter 17 | Behavior Management and Treatment Intervention Policy | |
|---|---|---|---|
| | | | |
| Effective Date | January 2019 | | |
| Expiration Date | January 2020 | | |
| | This policy will be reviewed annually | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Chief Clinical Officer | | |
| | Medical Director | | |
| | Operations Committee, Chair | | |

**Purpose:** To establish that Centers' clinical and direct care staff utilize collaborative behavior management and treatment interventions that assist individuals served to be self-directive, nurture pro-social skills and develop positive choices.

**Policy:** To ensure current best practices are applied to maintaining collaborative behavior management and treatment interventions through clearly defined guidelines and training.

**PROCEDURES:**

I. Treatment at Centers is anchored by a foundation of Trauma Informed Care.
   A. Principles of TIC are utilized in all facets of treatment to be trauma sensitive, minimize re-traumatization and offer client choice.
   B. Current best practices utilized have a foundation of TIC or are aligned with TIC principles.

II. The Stage of Change Model is a core element for treatment that guides clients through a behavior change process fostering self-motivation and readiness to act on a new healthier behavior, accepting individualized strategies and outcomes. This construct refers to behavioral change as a "process involving progress through a series of stages."
   A. The treatment team assesses which stage of change the clients begin with at admission.
      a. The names of the stages are modified for clients to better comprehend.
         a. Learning level-precontemplation
         b. Acceptance level-contemplation
         c. Action level-Action
         d. Maintenance Level-Maintenance
         e. Discharge Planning Level-Relapse Prevention
      b. A client could start at any of the first 3 levels depending on their understanding of the need for treatment and motivation to work on their goals and objectives.
      c. The client transitions to the next stage when they are ready.
         a. This change is in collaboration with the treatment team, including the family.
         b. Validation verbally or through a more formal means (certificate, celebration in group, etc) should be provided with each stage advancement.
         c. Clients may be in a different stage for different need areas, such as a client may be in Action for improving social skills but in Learning for substance abuse.
      d. The Treatment Team provides the type of interventions based on the stage of change the client is in.
      e. As the client reaches the Discharge Planning Level the client and their family/guardian should be preparing for transition back into their home.

III. Structured and consistent Incentives are utilized so clients may earn individual and group rewards based on exhibiting positive behaviors, characteristics and strengths. Incentives are

to be motivating to clients and as a result as much as possible the types of incentives should be directed by the clients themselves. Suggestions may evolve from individual feedback or via the Client Council. Incentives should be "normal" motivating activities based on age and functional level of clients.

A. Incentives are developed and provided consistently to reward and motivate clients to make positive change.
B. These incentives should be meaningful to the clients and as individualized as possible.
C. Individual and group incentives may be provided to incentivize targeted strengths, positive characteristics and/or behaviors.
D. Incentives shall be designed to provide as scheduled to adhere to positive reinforcement best practices.

IV. Conscious Discipline or current best practice is utilized in the classroom setting to provide a consistent, trauma sensitive-based milieu and curriculum to teach and role model effective social skills and classroom behaviors to foster enhance classroom learning. This model offers thorough training for the staff and a suite of coping strategies for individual and group benefit. These techniques are common in client's home classrooms, which facilitates a seamless transition back to the home classroom with techniques honed by the client and familiar to the teacher. These techniques may also be modeled for parents/guardian as well.

A. Staff utilize an Assertive approach to be directive, instructive and non-judgmental with clients.
B. Staff demonstrate Composure techniques to model calmness in the classroom.
C. A set of skills are taught to empower effective communication instead of utilizing aggression or other forms of maladaptive behaviors.
D. An array of activities are conducted to facilitate structure and enhance learning.
E. The Treatment Team is to share the skills and activities that have benefited the client with the family/guardian and teacher as the client transitions back to their home classroom.

V. Family-Driven Care in residential recognizes the importance of the child's place in the family and how identifying that the family is a collaborative partner and vital in recovery. Shared decision making, treatment planning and responsibilities for outcomes is a collaborative process between client, family and treatment team. Empowering families facilitates successful transitions after residential discharge equipped with a suite of skills, treatment strategies, effective support network and contacts for relapse prevention.

A. Family members/guardian are invited and expected to participate as part of the treatment team to assist in formulating the goals, objectives and interventions on the treatment plan, contribute to the development of individualized behavior modification practices, and incentives that assist in motivating their loved one to change.
B. Family members are educated about and expected to participate in discharge/transition planning at admission and participate in ongoing changes to the plan.
C. Family is offered materials for best practice interventions, especially the interventions provided to their loved one.
D. Family is consulted and afforded the opportunity to direct treatment/behavior protocol modifications as treatment barriers are presented.
E. Families assist the team in developing a relapse prevention plan prior to discharge and to understand how to operationalize any behavior management protocol utilized in treatment transitioned to the home.

VI. Behavior management and treatment interventions are approved for use in the following programs at The Centers:

A. 24 Hour care settings
B. Day Treatment Services
C. Therapeutic Family Homes Program

VII. Each program will use a system of interventions tailored to the specific needs of the individual it serves, designed to promote positive behavior change. The interventions will provide the client an opportunity to identify, control and resolve inappropriate behavior and plan alternative and productive strategies that promote progress in treatment. The systems of interventions could include the following:

A. The Power of Choice program, which would empower clients to make good behavior decisions as they progress through the Stages of Change throughout their treatment.
B. The use of Motivational Interviewing that will assist the client in eliciting change talk, while assessing their level of self-efficacy towards treatment progress.
C. Each client's behavior is separately monitored for compliance with the systems of intervention.
D. A client's behavior will be assessed continuously throughout the course of treatment.
E. When the treatment team determines that a client's behavior necessitates a special protocol, that protocol will be developed.

VIII. In cases which behavior is resistant to change, individualized behavior protocols targeting specific problematic behavior will be used to formally identify behaviors as well as the interventions and procedures for change.

A. Individuals and families will have opportunity to identify problematic behaviors and interventions which may be used.
B. The individual or family has the right to request an individual behavior protocol
C. The protocol will always be a trauma-informed approach being sensitive to experiences of the individual.
D. All aspects of the target behavior will be considered including environmental and contextual factors, skill or performance deficits associated with it, strengths, frequency, duration and intensity of target behavior.
E. Behavioral assessment will continue throughout treatment.
F. The individualized behavior protocol will always be aligned with the Treatment Plan and documented in the clinical record.
G. This plan is a separate document from the treatment plan. At a minimum, each protocol will incorporate the following elements:
    a. target/problem behavior;
    b. adaptive/replacement behavior;
    c. method of implementation: strategy, support, teaching methods, motivation and reward if used, frequency and circumstances under which the plan will be implemented;
    d. conditions for discontinuation;
H. This protocol is updated at each treatment plan review, at a minimum.
I. Centers expressly prohibits the use of aversive procedures for behavior management and treatment intervention. Specifically, the following procedures are prohibited:
    a. Procedures that deny any basic needs, such as nutritional diet, water, shelter, and essential, safe and appropriate clothing;
    b. Corporal punishment;
    c. Fear-eliciting procedures;
    d. Any intervention that is implemented by another individual served;
    e. Mechanical restraint
    f. Intentional exposure to unpleasant or noxious stimuli
J. Any restriction to an individual's rights is in accordance with agency policy as outlined in Chapter 8 "Client Rights and Responsibilities."
K. All behavior management and treatment interventions are reviewed periodically by qualified competent staff.
    g. Licensed clinical staff in programs have input to the design of behavior management and treatment interventions.
    h. Supervision and monitoring of behavior management and treatment interventions is provided by clinical staff which includes physicians, clinicians and nurses.
    i. All changes or discontinuation of behavior management and treatment interventions are made by the client's treatment team under the direction of the physician, clinician and/or nurse.
L. Staff involved in the implementation of behavior management and treatment interventions is trained, competent, and supervised.
    j. Staff are trained within their programs to properly use behavior management and treatment interventions.

k. The skills and knowledge of staff to use behavior management and treatment interventions is assessed on an ongoing basis.
l. Staff demonstrate competence in the specific behavior management and treatment intervention procedure before implementing the procedure.
m. Staff are supervised during the use of behavior management and treatment interventions.

M. Time out is an acceptable intervention. Refer to Chapter 13 Time Out Policy.

IX. Restoration (repair) plans to be created by clients.
Centers clients may be asked to do a Restoration (or Repair) plan when they have manifested behaviors that are unacceptable or inappropriate, cause emotional harm to others or self, and also for other infractions. Examples of behaviors that might warrant a restoration plan are threats toward others, safety plan violations, stealing, repeatedly having contraband, property destruction, racial slurs or gang signs or talk.

A Restoration Plan is intended to make the client introspective of their behaviors, to recognize what they did that was inappropriate or unacceptable, to contribute a better way to have handled the situation, and to conceptualize what they could have done differently.

Under no circumstance is a Restoration Plan forced or punitive, but if not completed in a specified amount of time, the client may be given a consequence. It is sometimes intended to be a choice. And the client must be held accountable for the time frame that it would need to be turned in.

Behavior plans should include the following and the client needs to be guided to create the plan.

- The behavior that required the plan and a brief summary of what happened
- Could the negative behavior have been prevented
- Client's responsibility in what happened
- Consequences the client thinks are appropriate for the behavior
- Is the client willing to engage in conflict resolution or problem solving if another client or staff is involved
- Is the client willing to apologize
- Ways in which the client could do better in future if the negative behaviors are repeated.

Restoration Plans must be assigned and approved by the nurse or clinician but the client may choose to get assistance from a QBHP.

X. Centers collects and analyzes data on the use of behavior management and treatment interventions in order to monitor and improve performance.

CENTERS FOR YOUTH AND FAMILIES

| Policy/Number | Chapter 16 | Emergency Safety Interventions | |
|---|---|---|---|
| | | | |
| Effective Date | April 2018 | | |
| Expiration Date | April 2020 | | |
| | This policy is reviewed every 2 years. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Chief Clinical Officer | | |
| | Medical Director | | |
| | Operations Committee, Chair | | |

**Policy**: Centers for Youth and Families advocates the use of non-physical techniques as the preferred behavior management intervention. Physical holding, chemical restraint and seclusion are used only when there is **imminent risk** of harm to self, others or property and only when non-physical interventions are ineffective.

**Purpose:** To provide guidance to staff in the use of emergency safety interventions.

**Philosophy:** The Centers is committed to preventing and reducing the use of physical holding, chemical restraint and seclusion. When physical holding, chemical restraint or seclusion is necessary, the client's safety and dignity must be preserved, and each intervention must be discontinued as soon as the client meets criteria for discontinuation. Centers makes every effort to base its staffing levels and assignments on a variety of factors including the following: staff qualifications, the physical design of the environment, diagnoses, co-occurring conditions, acuity levels, and age and developmental functioning of clients. Non physical interventions are the first choice unless safety demands an immediate physical response.

## I. GENERAL DEFINITIONS APPLICABLE TO ALL PROGRAMS:

"Emergency Safety Intervention" is the use of physical holding, chemical restraint or seclusion as an immediate response to an emergency situation.

"Emergency Safety Situation" is unanticipated client behavior that places the client or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined here.

## II. GENERAL PRINCIPLES:

A. Corporal punishment or other fear eliciting procedures will not be used under any circumstance.
B. Physical holding, chemical restraint and seclusion are to be used only when there is imminent danger of a client causing harm to self, others or property.
C. Each client has the right to be free from physical holding, chemical restraint or seclusion, of any form, used as a means of coercion, discipline, convenience or retaliation.
D. Physical holding, chemical restraint or seclusion will be discontinued when the emergency safety situation has ceased, even if the physical holding or seclusion order has not expired.
E. Physical holding and seclusion must never be used at the same time.
F. Only the least restrictive intervention necessary will be used for each emergency safety situation.
G. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the client's chronological and developmental age; size; gender; physical, medical and psychiatric condition; and personal history (including any history of physical or sexual abuse).
H. Food will not be used as a reward or punishment and clients may not be denied their right to eat.
I. Verbal de-escalation interventions will be exhausted before a more restrictive intervention is initiated.

J. Specific examples of approved verbal de-escalation/behavior management interventions requiring no special authorization or order include, but are not limited to: evading, ignoring, redirection, verbal feedback, modeling, rewards and time out.
K. Under no circumstances should one client be asked or allowed to participate in an emergency safety intervention on another client.
L. Emergency interventions must not exceed 30 minutes, either when used alone or in combination, i.e., the total length of time an intervention or combination of interventions may last is 30 minutes per incident.
M. Specific criteria for release from the intervention must be clearly stated to the client and the intervention discontinued as soon as criteria are met.
    1. A client exhibiting any signs of distress while in physical holding must be removed immediately and an alternative intervention be identified, if needed, and must be in consultation with the physician.
    2. If the criteria are to be calm for a certain number of minutes, staff must watch closely and release the client in a timely fashion.
    3. If the criteria are to accept redirection, staff must prompt the client to let staff know when he/she is ready for redirection after an acceptable period of calmness.
    4. If staff observes an increase in anger and frustration every time he/she speaks, staff should be quiet and let the client calm down.
    5. Stimulation must be limited as much as possible to enable the client to calm down.
N. Post Intervention Debriefings
    1. Post intervention debriefings must occur within 24 hours after the use of any form of physical holding, chemical restraint or seclusion. Any staff involved in the intervention cannot lead the debriefing.
    2. All staff involved in the intervention must be present except when the presence of a particular staff person might jeopardize the well-being of the client.
    3. Other staff may be included, if appropriate, as well as the parent/guardian if he/she chooses to be present.
    4. The discussion will take place in a language that can be understood by the client and the parent/guardian, if present.
    5. The discussion will provide an opportunity for the client and staff to discuss the circumstances resulting in the use of physical holding, chemical restraint or seclusion and strategies to be used by staff, the client, or others that could prevent future use of physical holding or seclusion.
    6. All staff involved in an emergency safety intervention and appropriate supervisory or administrative staff must conduct a debriefing session and sign the appropriate section on the Emergency Safety Intervention form. The debriefing session must include, at a minimum, a review and discussion of the following:
        a. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
        b. Alternative techniques that might have prevented the use of the physical holding or seclusion;
        c. The procedures, if any, that staff are to implement to prevent any recurrence of the use of physical holding or seclusion;
        d. The outcome of the intervention, including any injuries that may have resulted from the use of physical holding or seclusion.
O. Post Intervention Procedures:
    1. If the parent/guardian is not present, he/she must be notified of the intervention as soon as possible but no later than 24 hours after the occurrence.
    2. The information given includes a description of the antecedent and the actual behavior that resulted in the intervention, as well as a description of less restrictive interventions tried.
    3. In the event that the parent/guardian cannot be contacted by telephone within 24 hours after at least two attempts, a letter will be sent to the parent indicating the general nature of the incident with a directive to call the nurse or clinician for specific information.
    4. Attempts to contact parent/guardian will be documented in the EMR.

P. Documentation Requirements
    1. The use of an emergency safety intervention is clearly documented on the Emergency Safety Interventions Reporting form by the staff who initiated the procedure.
    2. The ESI form is scanned and forwarded to Risk Management within 24 hours. The original form, complete with all required signatures, is forwarded to Risk Management within five working days of the intervention.
    3. In residential programs, verbal orders for personal holding or seclusion are documented by the nurse who received the orders as described in this policy.
    4. In residential programs, the physician completes the order by signing it and includes the date and time of signature, immediately.
    5. In residential programs, the physician or an RN trained and competent in assessment procedures performs the face to face evaluation within one hour of the initiation of the restraint.
    6. Debriefings are documented on the form and become a part of the client record.
    7. Injuries to clients as a result of an emergency safety intervention require staff to meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. This is documented on the Plan to Prevent Future Injuries section of the Emergency Safety Form. Staff injuries are documented on the ESI form and on an incident reporting form.
    8. The ESI form includes the date and time of notification, as well as the name of the staff who made the notification. Parental notification of the use of an emergency safety intervention is also documented on this form. The ESI form becomes a part of the client record in the EMR.
    9. Serious injuries should be reported to the Child Abuse Hotline and licensing, as appropriate, with documentation included in the EMR that such reports were made. Refer to Page 6, Section K of this policy for a detailed description of serious injuries. All serious injuries occurring as a result of an emergency safety intervention must be documented on the ESI form and on an Incident Report Form and forwarded to Risk Management before the end of the shift on which the injury occurred.
    10. If the client receives three or more holds (3 separate ESI Forms) within seven days, the clinician must review the client's treatment plan. The clinician should give careful consideration to what changes may need to be made in client's treatment (i.e., new goals/objectives, individual behavior protocol, medication change). The Treatment Plan review must indicate that the purpose of the review was due to the client's receipt of multiple holds within a seven day period.

Q. An approved behavior management program is used in all Centers programs. Staff and therapeutic foster parents receive ongoing training and demonstrate knowledge and competency of:
    1. Techniques to identify staff and client behaviors, events, and environmental factors that may trigger emergency safety situations;
    2. The use of nonphysical intervention skills, such as de-escalation, evasion, mediation conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations;
    3. How to recognize and respond to signs of physical distress in clients who are being held.

R. At the time of admission, Centers must:
    1. Inform the client/parent/guardian of the policy regarding emergency safety interventions;
    2. Communicate the policy in a language they understand;
    3. Determine whether the parent wishes to be part of a debriefing within 24 hours after an intervention (rather than receiving a report after the intervention debriefing via telephone- for those interventions when the parent/guardian is not present)
    4. Obtain a written acknowledgment from the client/parent/guardian that they are informed of this policy and either chose to participate by phone within the 24 hour time limit or to be notified by telephone after the debriefing (for those interventions when the parent/guardian is not present)
    5. A summary of this policy is provided to the client/parent/guardian. The entire policy is available upon request.
    6. The child advocacy agency is the Disability Rights Center (501-296-1775) in Little Rock (or 800-482-1174 toll free). The address is 1100 N. University Ave., Ste. 201, Little Rock, 72204. Additionally, the Child Abuse Hotline number is 800-482-5964.

## III. Education and Training

A. Training is provided by individuals who are qualified by education, training and experience.
B. Training includes exercises in which staff successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
C. Staff are trained and demonstrate competency before participating in an emergency safety intervention.
D. Staff are trained as follows:
    1. Residential, Day Treatment Services and Outpatient trained every 6 months
    2. TFHP, Access and Emergency Services trained annually
E. Training and demonstration of competency is documented in the Staff Development Department.
F. All training programs and materials used by The Centers are available for review by external governmental and accrediting agencies.
G. Destiny House uses an alternate behavior management program approved by Rite of Passage.

## PROGRAM SPECIFIC PROCEDURES

### Psychiatric Residential Treatment

A. There are two interventions that may be used only in residential treatment and only upon order of the physician in response to an emergency safety situation:
    a. **"Seclusion"** is the involuntary confinement of a client alone in a room or in an area from which he/she is physically prevented from leaving.
    b. **"Drug used as a restraint"** is any drug that: is administered to manage a client's behavior in a way that reduces the safety risk to the client or others; has the temporary effect of restricting the client's freedom of movement; is not a standard treatment for the client's medical or psychiatric condition.
B. Physician's Orders
    a. Only a Licensed Independent Practitioner with specialized training and experience in the diagnosis and treatment of mental diseases may order the use of seclusion or restraint.
    b. An order for restraint or seclusion must not be written as a standing order nor on an as-needed basis.
    c. A physician's order may not exceed thirty minutes.
        i. When physical holding, chemical restraint or seclusion is terminated before the time-limited order expires, that original order cannot be used to reapply the physical holding or seclusion even if the original thirty minutes has not elapsed. A new order for physical holding or seclusion must be obtained.
        ii. Appropriate documentation must be completed for all emergency safety interventions, and further for each physician's order, that is, any series of interventions that exceed 30 minutes and require an additional order.
    d. The order for physical holding, chemical restraint or seclusion must be issued by the treatment team physician or Medical Director. If unavailable the physician covering for the treatment team physician may issue the order.
    e. If the physician is not available to order the use of seclusion, chemical restraint or physical holding in writing, the physician's verbal order must be obtained by a nurse at the time the emergency safety intervention is initiated by staff.
        i. The nurse writes the verbal/telephone order in Physician's Order section of the client record and indicates:
            a. the date and time the order was obtained;
            b. the name of the physician issuing the order;
            c. the specific emergency safety intervention(s) ordered including the maximum length of time authorized for use (not to exceed a combined total of 30 minutes per order);
            d. justification for the use of the interventions;
            e. orders must be written and read back to the physician for verification before the phone call is terminated.
            f. The nurse indicates "VORB" (verbal order read back) or "TORB" (telephone order read back) at the end of the entry.
    f. The physician's verbal order must be followed with the physician's signature verifying the verbal order within 5 days.

g. The ordering physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.
h. Each order must be limited to no longer than the duration of the emergency safety situation and under only very limited circumstances may it exceed 30 minutes.
    i. Specifically, the combined time for all interventions used under a single order MUST NOT exceed 30 minutes without the express order of the physician.
    ii. At the end of 30 minutes, a separate order must be obtained from the physician if the physician determines that the intervention(s) should continue.
    iii. Time attributed to each type of intervention used must be correctly documented on the form.

C. Seclusion

A. Seclusion may be chosen as an intervention only when indicated on the client's treatment plan and only as ordered by the physician.
B. The client must be searched for contraband, and shoes and belt must be removed before closing the door to the room.
C. Specific criteria for release from the intervention must be given to the client and the intervention discontinued as soon as criteria are met.
    1. A client exhibiting any signs of distress while in seclusion must be removed immediately and an alternative intervention be identified if needed.
    2. Criteria for release may include being calm for a specified period of time, with the understanding that being calm does not necessarily mean sitting or standing in one spot.
    3. Since an order for seclusion may not exceed 30 minutes, the length of time the client is to be calm must be reasonable
D. A room used for seclusion must:
    1. Allow staff full view of the resident in all areas of the room; and
    2. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.
E. The client must be constantly monitored and assessed by clinical staff (i.e., nurse).

D. Post Intervention Procedures

A. Within one hour of the initiation of the emergency safety intervention, a physician or an RN trained by the physician and competent to perform the assessment, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to:
    1. the client's physical and psychological status;
    2. the client's behavior;
    3. the appropriateness of the intervention measures;
    4. any complications resulting from the intervention;
    5. the above information is to be documented in the client record.
B. The ordering physician (if different from the treatment team physician) must:
    1. consult with the client's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required restraint or seclusion;
    2. attending physician will sign ESI form upon return.
C. Clinical staff (i.e., a nurse) trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the client and the safe use of restraint or seclusion throughout the duration of the intervention.
    1. If the emergency safety situation continues beyond the time limit of the physician's order for the use of the intervention, a nurse must immediately contact the ordering physician to receive further instructions.
    2. A physician or a nurse trained in the use of emergency safety interventions must evaluate the client's well being immediately after the restraint is discontinued or the seclusion is ended.
    3. A physical assessment must be completed by the nurse and documented immediately following release from the intervention.
D. For any single intervention or combination of interventions that exceeds 15 minutes, the reasons for continuing the intervention(s) will be documented on the appropriate form.

E. If an injury has occurred to the client, the form will include a plan to prevent future injuries. Supervisor staff must meet with the staff involved and evaluate the circumstances of the incident in order to develop the plan.
F. If an injury occurred to staff, this is noted on the ESI form and an incident report must be completed and workers comp procedures followed if indicated.
G. The staff member who implemented the intervention must complete the form before the end of the shift on which the intervention occurred.
H. A client debriefing and a staff debriefing must occur within 24 hours of the intervention, to be conducted by supervisory staff or a clinician, and must be fully documented on the appropriate form.
I. Parent/guardian notification must also occur within 24 hours of the intervention and be properly documented to include date, time and name of staff member who made the notification.
J. The completed form (with all required signatures) must be forwarded to Risk Management within 5 days.
K. **Reporting of Serious Occurrences.** The Chief Executive Officer or designee must report any serious occurrence involving a resident to the Office of Long Term Care (501-682-6159 or 501-682-6171), the Disability Rights Center and to Licensing.
    1. Serious occurrences include death, suicide attempt and serious injury.
    2. Serious injury means any significant impairment of the physical condition of the client requiring outside medical care as determined by qualified medical personnel, including but not limited to lacerations, bone fractures, substantial hematoma, and injuries to internal organs.
    3. The event must be reported no later than the close of business the next day after the event occurred.
    4. The report must include the name of the client involved, a description of the occurrence, and Centers' address and telephone number.
    5. The client's parent/guardian must be notified as soon as possible and in no case later than 24 hours after the occurrence and documented in the client record.
    6. The clinician must document in the client's record that the serious occurrence was reported to the state Medicaid office and to the Child Abuse Hotline, including the name of the person to whom the incident was reported.
    7. Additionally, an incident report must be completed and submitted to Risk Management.
    8. Administration (CEO or designee) must report the death of a client to the regional CMS office.
L. The Medical Director is notified by the attending nurse when a client remains in a physical hold or seclusion for more than one hour or experiences two or more separate episodes of physical holding or seclusion within 12 hours.
M. Precautionary Status

    1. A client may be placed on precautionary status for one of the following:
        i. Assaultive precaution: client is at risk for doing harm to others
        ii. Suicidal precaution: client is at risk for doing harm to self
        iii. Non-Suicidal Self Harm (NSSH) precautions: Client is at risk of harm to self but not suicidal ie: cutting due to anxiety
        iv. Sexual Acting Out (SAO) or Sexual (SR) precautions: client is at risk for sexualized behaviors
        v. Elopement precaution: client is at risk for running away

    2. The level of attention necessary to address the pertinent issue(s) may vary. The appropriate level of precautions is determined by the physician or APRN in consultation with the nurse in the residential programs or with the clinical in the Destiny House program as follows:

        Level A:

        i. Client's room is searched for contraband while client is monitored by staff
        ii. Body search for contraband
        iii. 1:1 staff to client ratio
        iv. Client remains within arms' length of staff at all times
        v. Documentation of client status every 15 minutes

vi. Client prohibited from close interaction with peers

Level B:

i. Room search for contraband mainly for suicidal, NSSH or assaultive precautions
ii. Client to remain within staff eye sight at all times
iii. Documentation of client status every 15 minutes

3. Client's behavior is documented on the Precautionary Log Form while the client is on precautions. This form is to be scanned into the client's record in the EMR
4. All clients on precautionary status are restricted to the building.
5. All precautionary status's are to be reviewed and reassessed by the nurse or clinician and the physician or APRN every 24 hours. Any decrease in a precautionary status must be approved by a physician or APRN and an order would be entered by the nurse in the residential programs. No precautions are to be discontinued without the review and reassessment by the physician or APRN.

**DTS/Outpatient/TFHP/Destiny House**

A. For any single intervention or combination of interventions that exceeds 15 minutes, the reasons for continuing the intervention(s) will be documented on the appropriate form.
B. Following the intervention(s), a staff member will assess the client for injuries, and will document any noted injuries on the appropriate form.
C. If an injury has occurred to the client, the form will include a plan to prevent future injuries. Supervisory staff must meet with the staff involved and evaluate the circumstances of the incident in order to develop the plan.
    i. If an injury has occurred to the client, the form will include a plan to prevent future injuries. Supervisory staff must meet with the staff involved and evaluate the circumstances of the incident in order to develop the plan.
    ii. If an injury occurred to staff an incident report must be completed and is not made a part of the client record.
    iii. If outside medical attention is necessary to treat injuries to either client or staff, the program physician and/or Medical Director will be notified and an ambulance called if necessary.
    iv. The parent will be notified immediately and asked to meet Centers' staff who will accompany the client to an emergency medical facility.
D. The staff member who implemented the intervention must complete the form before the end of the shift on which the intervention occurred.
E. A client debriefing and a staff debriefing must occur within 24 hours of the intervention, to be conducted by supervisory staff or a clinician, and must be fully documented on the appropriate form.
F. Parent/guardian notification of the emergency safety situation and debriefing must occur within 24 hours of the intervention and be properly documented to include date, time and name of staff member who made the call.
G. The completed form (with all required signatures) must be forwarded to Risk Management within 5 days.
H. The Medical Director will be notified of any client who needs two or more interventions in a 12 hour period.

**CENTERS FOR YOUTH AND FAMILIES**

| Policy/Number | Chapter 69 | Documentation of Service Provision Policy | |
|---|---|---|---|
| | | | |
| Effective Date | June 2016 | | |
| Expiration Date | June 2019 | | |
| | This policy is reviewed every 3 years. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Clinical Operations Director | | |
| | Chief Executive Officer | | |

**Purpose**: To provide general guidelines for the documentation of services provided to clients and/or their families by Centers for Youth & Families' staff.

**Policy:** All documentation regarding services provided must be both accurate and comprehensive. Documentation shall reflect the actual services provided to clients and/or their families, and the extent of the progress of the individuals receiving services.

**Procedures:**

Clinical Documentation:

1. All clinical documentation forms must be completed by the assigned licensed clinician. This includes, but is not limited to:
   - A. Child Diagnostic Assessment
   - B. All Treatment Plans
   - C. Transfer/Discharge Summaries
   - D. Other clinical documentation requiring the signature of a licensed professional.
2. All notes from individual and group therapy must be completed by the assigned clinician.

Services Entries:

1. All service entries, at a minimum, shall contain the following information:
   - A. Services provided
   - B. Date and actual time of service rendered (time in/time out)
   - C. Name and credentials of individual providing services
   - D. Setting in which the services were rendered
   - E. Relationship of the services to the treatment regimen as described in the Treatment/Service Plan
   - F. Updates describing the client's progress
2. Documentation must be individualized to the client and specific to the services provided, duplicated notes are not allowed.
3. Documentation must be completed at the time services are rendered.
4. Documentation must be as legible as possible.
5. Blank spaces will not be left in the documentation.
6. All notes and clinical impressions must be documented in the client record; Centers' clinicians and service coordinators are prohibited from keeping any clinical information outside the client record (sometime referred to as a soft chart or shadow chart).

Late Entries:

1. A late entry is defined as an entry regarding service provided that was not documented at the actual time service was delivered.
2. Staff should make every effort to avoid the necessity of making late entries.
3. Late entries should be designated as such. The date, time and type of service should be indicated, as well as the date and time of documentation.

Corrections:

1. Corrections will be made by revising the document in the Electronic Medical Record. The original entry will be legible along with the date, time and staff that made the correction.
2. The staff who made the incorrect entry will correct it.

3. The date and time of the correction will be evidenced in the Electronic Medical Record when the correction is made.
4. Corrections will be made as soon as the error or omission has been noted.

Alterations:

1. An alteration is a deliberate attempt to change rather than correct what is recorded.
2. Staff are not to make alterations to client records.
3. The client record must not be erased, blackened or altered with "white out".
4. Pages that have an error should not be removed from the chart or Electronic Medical Record.
5. Nothing should be added after an original entry has been made without referring to the earlier note.
6. If a page is damaged in some way (e.g. by liquid or tearing), it should be left in the client's chart (perhaps in a sealed envelope) along with a rewritten copy. Document the location of the original page on the rewritten copy.

Billing:
Centers will bill only for medically necessary services that have been performed and correctly documented.

Interns:
All entries into the clinical record by an intern must be countersigned by his or her supervisor at The Centers.

**CENTERS FOR YOUTH AND FAMILIES**

| Policy/Number | Chapter 63 | Medication Management | |
|---|---|---|---|
| | | | |
| Effective Date | January 2019 | | |
| Expiration Date | January 2020 | | |
| | This policy is review annually. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Medical Director | | |
| | Operations Committee, Chair | | |

**POLICY:** Centers for Youth and Families safely manages the medication of all clients.

**PURPOSE:** To ensure the safe and effectiveness of CFYF client's medication.

**PROCEDURE:**

1. Reconciliation Process all clinical programs
   A medication reconciliation form will be completed in all clinical programs at the time of admission based on information provided by the parent/guardian, adult client or documented information from previous providers regarding medication status. The information in the reconciliation will include the names of medications that the client takes with dosage, route of administration and frequency. Changes made to the medication regimen by a Centers provider at the time of admission will be included. If the client is not on medication at the time of admission, this will be reported on the form. At the client's discharge from a program, the reconciliation form will be completed with the same information specified on the form with all discharge medications including medication dosage, route of administration and frequency. At discharge, a copy of the form will be signed by the provider, nurse, parent/guardian or adult client and a copy of the discharge reconciliation will be provided to them. A copy of the signed document will be scanned into the EMR. If a parent/guardian or adult client is not available at the time of discharge, a copy of the discharge reconciliation form will be mailed to them, and this will be documented in the EMR.

2. A physician will assess the need for medication on an individual basis. All clients seen by the physician will receive a medication assessment at the higher levels of care. In the lesser restrictive programs, clients who are seen by the physician for a psychiatric evaluation or are referred for medication management will receive a medication assessment.
   a. The assessment will include review of the last psychiatric diagnostic assessment or psychiatric evaluation, mental health evaluation and psychological evaluation if available.
   b. Information will be obtained from the parent/guardian, the client, and the CYF clinician assigned.
   c. A history of current and past medications will be obtained.
   d. At a minimum, the physician will review and consider the following information in regard to the client:
      1. client's age
      2. client's sex;
      3. client's current medications;
      4. client's past medication use (if any);
      5. client's history of drug and alcohol use/abuse;
      6. client's diagnoses, comorbidities, and concurrently occurring conditions;
      7. client's relative laboratory values;
      8. client's allergies and past sensitivities
      9. client's height and weight
      10. client's pregnancy and lactation status if female.

3. All orders for medication must be written clearly and transcribed accurately.

a. The required elements of a complete medication order are
    1. Date of order;
    2. Time of order;
    3. The order itself with appropriate abbreviations only (see Chapter 44 Client Records Policy Addendum A and B) and the indication for use.
    4. Physician's signature including name in print and credentials;
    5. In case of a verbal/telephone order, the physician must validate the order within 5 days in Monticello and 3 days in all other programs in the EMR or for paper orders.
b. If an order is taken verbally by the nurse, he/she will write down the complete order and then read it back to the prescriber to verify.
c. The nurse will then note "vorb" or "torb" "verbal order read back" or "telephone order read back" at the end of the order.
d. The indication for use will be specified
e. If the physician chooses to use a brand name drug the indication for use will be specified in the order and medical necessity as well as diagnosis will be included on the prescription.
f. In the event that drugs with look-alike or sound-alike names are being ordered, the order will be printed for clarity and verbal orders are read back for clarity. If it is determined that a client takes both of the sound-alike/look-alike medications, then the MAR and medications will be labeled with "SALAD" stickers to alert staff. A list of Sound-Alike Look-Alike Drugs possibly used by the facility is included in this policy (Page 7) and is posted in the nursing stations.
g. In the event that a medication order is incomplete, illegible or unclear, the nurse will receive clarification from the physician prior to placing the order with the pharmacy. The nurse will document the order, read back to the prescriber and ensure accuracy prior to implementing.
h. All medications are used in a judicious manner when a targeted behavior or condition requires the use of multiple psychopharmacologic drugs.
    1. All medications are used within guidelines of established literature such as the PDR or Epostrophe.
    2. All dosages prescribed follow age-specific standards.
    3. When a client is not responsive to standard medications and where multiple psychopharmacologic drugs are considered, the Medical Director will be consulted for more than 5 psychotrophic medications.
        a. The Medical Director will discuss the medication with the physician to ensure appropriateness of medications.
        b. If the Medical Director is the prescribing physician, a peer review is completed by another physician within the agency.
        c. No more than one anti-psychotic medication will be used at a time.
    4. The AIMS will be administered prior to initiation of any antipsychotic medication and at no more than three month intervals in the residential programs and 6 months in the RSPMI programs thereafter in order to monitor a client for abnormal movements including Tardive Dyskinesia. The AIMS will also be done more frequently if indicated.
    5. The Medical Management staff will be made aware of medication side effects in the MAR.
i. The pharmacy delivers medications to nurse manager or designated nurse who will sign for medications and secure the medication ordered in a safe, locked area.
j. All medications received from the pharmacy are checked for accurate/appropriate labeling by the nurse and if any discrepancy is discovered, the medication is returned to the pharmacy by the nurse for accurate labeling.
k. All medications are properly and safely stored under conditions that assure their stability and secured so that unauthorized persons may not have access to them.
    1. Insulin is always stored in the refrigerator in the nurses' area on a separate shelf with a label on the shelf indicating "Insulin" to prevent confusion with other medications.
    2. All other high alert medications are listed in this policy (Page 9), posted in the nursing stations and safely managed and stored.
l. Only the prescribed dosage per client is removed from locked storage at the time of medication administration.
m. The following are specific orders utilized by Centers medical staff.

1. Standing Orders: A prewritten medication order and specific instructions from the prescriber to administer a medication to an individual in clearly defined circumstances as specified in the instructions.
2. Stat Orders: One time order for a medication prescribed for a specific condition, and generally used in acute, urgent or emergency situations.
3. Automatic Stop Orders: Specifically identified orders that do NOT include a date or time to discontinue are automatically stopped according to policy.
4. Taper Orders: Orders in which a dose is decreased by a specific amount with each dosing interval.
5. Range Orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or status of the individual served.
6. Orders for medication related devices, eg: inhalers, nebulizers or glucometers.
7. PRN Orders: Centers physicians do not utilize PRN orders except for over the counter medicines for minor medical conditions such as minor aches/pains, itching or medical conditions such as asthma.
8. Centers does not use summary (blanket) orders to resume previous medications.

4. Medications are safely and accurately administered.
   a. In 24/7 programs, medications are administered by a nurse who will do the following at each administration:
      1. Identify the client using at least two acceptable identifiers. Acceptable identifiers include:
         - client photograph in the client record
         - calling client's name and received affirmative answer
         - personal recognition by regular staff
         - client's date of birth
      2. Unacceptable identifiers include:
         - client's room number
         - physical location
      3. Verify that the medication selected for administration is the correct one based on the medication order and product label;
      4. Verify that the medication is stable based on physical examination and that the expiration date has not passed;
      5. Verify that there is no contraindication for administering the medication; such as an allergy to the medication
      6. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route.

5. Medication information is obtained during the initial Psychiatric Diagnostic Assessment or the psychological evaluation and is documented in the EMR. A Residential Medication Management note or Pharmacological Management note for RSPMI programs is used to document medication management in the client's EMR when first admitted and at every medication management visit thereafter.
   a. Only medications needed to treat the client's condition are ordered.
   b. In the 24/7 programs medical providers will perform the H&P. RSPMI program clients are referred to their PCP and this is documented in the EMR.
   c. An informed consent is obtained from the parent/guardian prior to initiating a new medication.
      1. The physician/nurse provides medication education to the parent/guardian and client, as appropriate, that describes:
         a. The recommended medication;
         b. The likelihood of achieving treatment goals with this medication;
         c. Risks, benefits and side effects of this medication;
         d. Alternative(s) (if any) including risks, benefits and side effects of alternative(s).
      2. The parent/guardian signs the Informed Consent and the physician. A copy is scanned in to the EMR, and if a paper copy is used, it is signed by the parent/guardian and the physician and scanned into the EMR and the paper copy is filed in the client record.
      3. When a guardian cannot come in to sign an informed consent in a timely manner, the following protocol will be followed:

a. The nurse will get in touch with the guardian via phone and will go over the entire Informed Consent form for the medication. All elements in the form will be explained to the guardian.
b. The nurse will ask the guardian if they want the medication started per the physician's recommendation. If the guardian has any questions or concerns, these will be addressed.
c. The call will be witnessed by another staff member in person, on another line, or as a second call to the guardian.
d. If the guardian agrees to authorize the consent, the nurse will add the following at the bottom of the form: "verbal consent obtained from parent (or guardian) and witnessed by ___." Both the nurse and the staff witnessing the consent will sign the form once authorization is obtained.
e. The physician will sign all consents obtained within 72 hours.
f. Every effort will be made by the nurse and physician to get the guardian to sign the form at a later date.

4. Informed consent is always obtained prior to a change in medication unless a life-threatening situation arises and the parent cannot be reached for consent. (General consent for treatment in emergencies has been obtained during the admission process). The parent is notified as soon as possible of the situation.

d. Medication education is provided for the parent/guardian and the client at the initiation of each medication and as needed thereafter.
e. The effects of medication on the clients are monitored.
   1. The client is visually observed by the nurse and other staff involved in treatment especially after the first does of medications.
   2. If undesirable changes are observed, the physician is immediately notified.
   3. The physician reviews medications at specified intervals and monitors via interview with the client and monitoring of lab results.

6. Medication education is documented in the client's chart on the MAR.
   a. Medication education includes the following:
      1. The name, dosage, route of administration and administration schedule of the prescribed medication;
      2. Target symptoms;
      3. What is likely to happen with medication vs. without medication;
      4. Side effects, risk/benefit factors;
      5. Rights of the client's parent/guardian to accept or refuse the medication;
      6. Consequences of stopping the medication or missing a dose.
   b. Medication education occurs with each administration in the more restrictive programs.
      1. Education is provided and documented by the nurse administering the medication.
      2. The client is encouraged to know the name, schedule, reason for medication and the side effects.
      3. Clinicians are educated annually regarding medication via clinicians' monthly meeting.

7. A process for response to and documentation of an adverse drug reaction has been established.
   a. Definition of an Adverse Drug Reaction:

      **Adverse Drug Reaction:** A response to a medicinal product that is noxious and unintended and that occurs at doses normally used in humans for the prophylaxis, diagnosis, or treatment of disease or for the restoration, correction, or modification of physiological or psychological function.

      **Significant Adverse Drug Reaction:** An adverse medication reaction experienced by an individual that requires intervention to preclude or mitigate harm or that requires monitoring to confirm that it resulted in no harm to the individual.

      **Adverse drug reactions include but are not limited to**:

      - hypersensitivity reactions (fever, rash, asthma, serum sickness, etc.)
      - drug interactions
      - drug response that necessitates or results in
        - complication of diagnosis
        - supportive treatment
        - prolonged stay in facility

- stopping the drug
- changing the drug
- death

b. Medications to counter act side effects or adverse drug reactions are stored in a locked box at each residential program. (see ORG-7 Pharmacy Plan for details.)
c. The nurse will obtain a STAT order from the physician to administer the appropriate medication from the locked box.
d. An Adverse Drug Reaction Form is completed by the nurse administering the medication and is routed to the treating physician.
e. In case of an ADR, the physician or physician on call must be notified ASAP for further disposition and treatment of the ADR. In case of Significant ADR, the Medical Director must be notified ASAP after the physician has been notified and treatment ordered.
f. The parent/guardian is notified by the physician/APRN when there is any adverse drug reaction.
g. The Medical Management Committee reviews and analyzes aggregated data on adverse drug reactions and makes recommendations as needed.
h. The original form is sent to the Risk Management Coordinator with a copy to the Medical Director.
i. No copies of the form are to be kept in the program.

8. A process for response to a medication error has been established.
   a. **Definition of a Medication Error:** A medication error occurs when there is a discrepancy between what a physician orders and what is reported to occur, regardless of how the client obtained the medication.
   b. The physician is notified and the client treated, if necessary.
   c. The nurse discovering the error completes a Medication Error Form.
   d. The original form is sent to the Medical Director with a copy to the Risk Management Coordinator. The Medical Director routes the original form to Risk Management Coordinator after completing the appropriate sections.
   e. The parent/guardian is notified by the nurse of the medication error.
   f. No copies of the form are to be kept in the program.
   g. A modified root cause analysis is conducted within 7 working days in the program in which it occurred on Type I and Type II medication errors.
   h. Medication errors identified by or reported to the pharmacist are monitored via a quarterly Pharmacy Report and reviewed by the Medical Management Committee.

9. Medication protocols are followed for all medication.
   a. Two identifiers are used before medication is administered and include a combination of the following:
      - client photograph in the client record
      - calling client's name and received affirmative answer
      - personal recognition by regular staff
      - client's date of birth
   b. The Medical Director reviews the Performance Indicators for Medication Management monthly as provided by the pharmacist.
   c. Additionally, these data are reviewed quarterly by the Medical Management Committee.

10. Critical Test
    a. A critical test is a medically necessary lab test that is ordered by the physician without which appropriate treatment would be delayed or jeopardized to a point of possible harm to the client. The test is urgent and results should be available from the lab within 4 hours or earlier. An example of a critical test would be a lithium level in suspected lithium toxicity, or a test ordered when there is a medical condition needing immediate lab results such as a suspected overdose.
    b. If the results of the test ordered are not available within 4 hours or earlier, the physician will be notified, and the physician or designee will call the Laboratory to get the results and discuss the delay. If the delay is lengthy or a trend is noted that the Lab is frequently tardy with results, the Medical Director will be notified. The Medical Director will work with the

Nurse Manager to contact the lab to get the deficiency corrected. The Physician and Medical Management Committee will be updated and involved as appropriate.

11. Medication education for direct care staff will be provided through the clinicians' meeting, program meetings, and the treatment planning process.

12. Centers evaluates its medication management system through reports from the Pharmacy and internally generated reports including the DUES peer reviews to analyze trends or issues and to identify opportunities for improvement.

13. Physicians/APRN review literature (for example, AACAP Journal) practices and update protocols as new information is made available. In order to keep up with standards and practice and update protocols as appropriate.

14. Safety and Storage of Centers Medication Prescription Books & Physician Stamps

    a. Prescriptions are sent via the EMR for most psychiatric medications.
    b. Prescriptions for stimulant medications must be written on Tamper Resistant paper and prescription pads must be stored in a locked cabinet.
    c. When paper prescriptions are used, unused prescription books will be stored in a locked cabinet. The Medical Director, Nurse Managers, and designated physicians/nurses are the only staff authorized to access blank prescription books. Medical Director will have a key to the cabinets to be stored in a lock box or cabinet.
    d. Prescription books in use by the nurse will be locked at all times in the medication cabinet except when accessed to write prescriptions. Physicians needing to write prescriptions will obtain the book from the nurse and return the book to the nurse for lock up when done. A residential physician may also retain a book for their use under lock and key at all times, except when in use. Prescriptions will be written sequentially and only one book at a time will be used.
    e. In all non residential programs, prescription books in use will be locked in a cabinet by the nurse and accessed only when prescriptions are written. Physicians will get the book from the nurse and return the book to the nurse when the prescriptions are completed.
    f. When a prescription book is complete, the nurse will store the completed book in a designated locked cabinet for past and completed prescription books.
    g. All physician stamps will be stored in a locked cabinet when not in use by the nurse or the physician.

15. All multi-dose vials will be checked for proper labeling by the nurse at every administration to include the correct dates of entry and expiration. This will be monitored for compliance by the nurse managers in the RTCs and the nurse in the lower levels of care programs. Also, the pharmacist will check the multi-dose vials during monthly medication inspections to ensure appropriate labeling of entry and expiration dates. Pharmacist will report any deficiencies to the Medical Director, Nurse Managers/Nurse as soon as possible and the Medical Management Team when it is scheduled.

16. Any new medication or change in medication will be entered into the EMR medication portal by the nurse receiving the order at the time the order is received. The portal needs to be current at all times. Daily chart checks in the residential programs will include the reconciliation of the medications in the MARs with the medications in the portal. If the portal meds do not reconcile with the MARs, the portal will be updated by the nurse performing the chart checks. Nurse Managers will designate an alternate nurse to complete the above in case of pool or agency nurses working without access or orientation to the EMR.

17. In non-residential programs, the nurse will update the portal at every client visit for medication management and will verify with the parent/guarding that the medications are correct.

18. In DTS, the nurse will keep the portal updated during working days.

# Centers for Youth and Families
# Look-Alike / Sound-Alike Medications

| Potential Problematic Drug Names | BRAND NAME (generic name) | Potential Errors and Consequences | Specific Safety Strategies |
|---|---|---|---|
| 1. hydroxyzine and hydralazine | VISTARIL (hydroxyzine pamoate)<br>ATARAX (hydroxyzine HCl)<br>APRESOLINE (hydralazine) | Because the first 4 letters are identical, they are sometimes stored next to one another. They have similar dosage strengths (10,25, 50, 100mg) and are both tablets. Hydroxyzine is an antihistamine and Hydralazine is an antihypertensive agent. Confusion could lead to serious adverse drug events. | Hydralazine is not on Center's formulary. They are not kept next to each other at HealthCare Pharmacy and are on separate shelves. The generic brand purchased for each drug uses emphasized "tall man" letter characteristics |
| 2. Insulin Products<br><br>Lantus and Lente<br>Humalog and Humulin<br>Novolog and Novolin<br>Humulin and Novolin<br>Humalog and Novolog<br>Novolin 70/30 and Novolog Mix 70/30 | Lantus (insulin glargine)<br>Lente (insulin zinc suspension)<br>Humulin (human insulin)<br>Humalog (insulin lispro)<br>Novolin (human insulin)<br>Novolog (human insulin aspart)<br>Novolin 70/30 (70% isophane insulin and 30% insulin regular)<br>Novolog Mix 70/30 (70% insulin aspart protamine suspension and 30% insulin aspart) | Similar names, strengths and concentration ratios of some products (e.g. 70/30) have contributed to medication errors. Mix-ups can occur between the 100 unit/ml and 500 units/ml insulin concentrations. | Diabetic patients are not common at the Centers, so multiple products are typically not stored. Insulin bottles are labeled directly on the bottle and on the box. Exact name of product dispensed is written on the MAR. Consider auxiliary labels for newer products to differentiate them form the established products. Also, apply bold labels on atypical insulin concentrations. |
| 3. metformin and metronidazole | GLUCOPHAGE (metformin)<br>FLAGYL (metronidazole) | Potential serious mix-ups between metformin and metronidazole due to look-alike packaging and similar first 3 letters. Metformin is contraindicated in certain clinical situations where use might contribute to lactic acidosis. | HealthCare Pharmacy's computer pulls up a list of drugs when MET is entered. Metformin is not on the Center's formulary. |
| 4. Celebrex and Celexa and Cerebyx | CELEBREX (celecoxib)<br>CELEXA (citalopram HCl)<br>CEREBYX (fosphenytoin) | Similar beginning letters with the letter x in the name can contribute to confusion which could lead to a decline in mental status, lack of pain or seizure control, or other serious adverse event. | Celebrex and Cerebyx are not on Center's formulary. Celexa is dispensed as the generic citalopram. |
| 5. clonidine and Klonopin | CATAPRESS (clonidine)<br>KLONOPIN (clonazepam) | The generic name for clonidine can easily be confused as the trade or generic name for clonazepam. The tablets are similar in size and color. | Both drugs are dispensed as generic. |

| | | | |
|---|---|---|---|
| 6. lorazepam and alprazolam | ATIVAN (lorazepam)<br>XANAX (alprazolam) | These benzodiazepines have different potencies. Confusion can cause excessive sedation and risk of falls. | Alprazolam is not on the Center's formulary |
| 7. Zyprexa and Zyrtec | ZYPREXA (olanzapine)<br>ZYRTEC (cetirizine) | Name similarity has resulted in confusion between Zyprexa, an antipsychotic, and Zyrtec, an antihistamine. Zyprexa can cause dizziness and can cause mental problems if dose is not given. | Zyrtec is dispensed as the generic drug. |
| 8. Advicor and Advair | ADVICOR (lovastatin + niacin)<br>ADVAIR (salmeterol + fluticasone) | Similar beginning letters can cause confusion. Decreased control of asthma can occur. Niacin can cause a sever rash in some patients. | Advicor tables are not on Center's formulary. Advair is an inhaler that has instructions for use that include number of inhalations. |
| 9. Diflucan and Diprivan | DIFLUCAN (fluconazole)<br>DIPRIVAN (propofol) | Similar beginning and ending letters can cause confusion. Infection could become more severe if not treated properly with fluconazole. | Diprivan is not on Center's formulary. Diflucan is dispensed as the generic fluconazole. |
| 10. Effexor XR and Effexor | EFFEXOR XR (venlafaxine extended release)<br>EFFEXOR (venlafaxine) | Same medication, but different dosage forms. Decreased control of symptoms if XR is not given when prescribed. | HealthCare Pharmacy verifies all orders if strength does not match dosing time. |
| 11. folic acid and leucovorin calcium ("folinic acid") | FOLIC ACID (folic acid)<br>WELLCOVORIN (leucovorin) | Names can be confused due to similar letters. | Leucovorin is not on Center's formulary |
| 12. Lamisil and Lamictal | LAMISIL (terbinafine HCl)<br>LAMICTAL (lamotrigine) | Patients with epilepsy who do not receive Lamictal due to an error would be inadequately treated and could experience serious consequences. Conversely, patients erroneously receiving Lamictal would be unnecessarily subjected to a risk of potential side effects (including serious rash) and would miss important anti-fungal therapy. | Both medications are dispensed as the generic |
| 13. lamivudine and lamotrigine | EPIVIR (lamivudine)<br>LAMICTAL (lamotrigine) | Names can be confused due to similar letters. Lack of seizure or behavior control if given incorrectly. | Epivir is not on Center's formulary. |
| 14. Prilosec and Prozac | PRILOSEC (omeprazole)<br>PROZAC (fluoxetine) | Names start and end with similar letters and come in same strengths. Prilosec is a stomach medication and Prozac is an antidepressant. Depression could become more severe. | Both medications are dispensed as the generic |

| | | | |
|---|---|---|---|
| 15. tramadol and trazodone | ULTRAM (tramadol)<br>DESYREL (trazodone) | Names begin with similar letters. Depression could worsen | Tramadol is not on Center's formulary. |
| 16. Wellbutrin SR and Wellbutrin XL | WELLBUTRIN SR (bupropion sustained release)<br>WELLBUTRIN XL (bupropion extended release) | Same medication, but different dosage forms. Decreased control of symptoms if XL is not given when prescribed. SR is typically dosed twice a day and XL is given once a day. | HealthCare Pharmacy verifies all orders if dosing times do not match typical use of the medications. Generic drugs are dispensed from bottles labeled SR (twice a day) and XL (once a day) |
| 17. Zantac and Xanax | ZANTAC (ranitidine)<br>XANAX (alprazolam) | Similar sounding names can lead to confusion. Anxiety symptoms could worsen or stomach pain could increase. | Xanax is not on Center's formulary. |
| 18. Zantac and Zyrtec | ZANTAC (ranitidine)<br>ZYRTEC (cetirizine) | Names both start and end with same letters. Stomach pain could become more severe and allergy symptoms could worsen. | Both drugs are dispensed as the generic. |
| 19. Adderall and Inderal | ADDERALL (amphetamine salts)<br>INDERAL (propranolol) | Names sound familiar. Decreased control of blood pressure or lack of attention and behavior problems if dose mistaken. | Generic Adderall is used unless XR is behind name. Generic Inderal is used. |
| 20. Celexa and Zyprexa | CELEXA (citalopram)<br>ZYPREXA (olanzapine) | Names sound similar and both end in same 3 letters. Lack of control of psychotic symptoms or depression. | Celexa is dispensed as the generic drug. |
| 21. Depakote EC and Depakote ER | DEPAKOTE EC (divalproex sodium enteric coated)<br>DEPAKOTE ER (divalproex sodium extended release) | Same medication, but different dosage forms. Decreased seizure or behavior control if ER is not given. | HealthCare Pharmacy verifies all orders if they are different than previous order. |
| 22. Tegretol and Tegretol XR | TEGRETOL (carbamazepine)<br>TEGRETOL XR (extended release) | Same medication, but different dosage form. Decreased seizure or behavior control if XR not given. | HealthCare Pharmacy verifies all orders if they are different than previous order. |
| 23. Lithium and Lithium ER | LITHOBID, ESKALITH (lithium)<br>LITHOBID, ESKALITH (lithium ER) | Same medication, but different dosage form. Decreased seizure or behavior control if XR not given. | HealthCare Pharmacy verifies all orders if they are different than previous order. |

Recommendations for Preventing Drug Name Mix-ups

What prescribers will do:

- Maintain awareness of look-alike and sound-alike drug names as published by various safety agencies
- Clearly specify the dosage form, drug strength, and complete directions on prescriptions. These variables may help staff differentiate products.
- Encourage inpatients to questions nurses about medications that are unfamiliar or look or sound different than expected.
- Give verbal or telephone orders only when truly necessary. Include the drug's intended purpose to ensure clarity. Encourage staff to read back all orders, spell the product name, and state its indication.

What Centers' staff will do:

- Maintain awareness of look-alike and sound-alike drug names as published by various safety agencies. Regularly provide information to professional staff.
- Whenever possible, determine the purpose of the medication before dispensing or drug administration. Most products with look-alike or sound-alike names are used for different purposes.
- Accept verbal or telephone orders only when truly necessary. Encourage staff to read back all orders and state its indication.
- Consider the possibility of name confusion when adding a new product to the formulary. Review information previously published by safety agencies.
- Affix "name alert" stickers to areas where look-alike or sound-alike products are stored (available form pharmacy label manufacturers).
- Encourage reporting of errors and potentially hazardous conditions with look-alike and sound-alike product names and use the information to establish priorities for error reduction. Also maintain awareness of problematic product names and error prevention recommendations provided by ISMP (www.ismp.org) ; FDA (www.fda.gov) and USP (www.usp.org)

**ISMP List of High-Alert Medications in Community/Ambulatory Healthcare**

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors and minimize harm. This may include strategies like providing mandatory patient education; improving access to information about these drugs; using auxiliary labels and automated alerts; employing automated or independent double checks when necessary; and standardizing the prescribing, storage, dispensing, and administration of these products.

| Classes/Categories of Medications |
|---|
| antiretroviral agents (e.g., efavirenz, lamiVUDine, raltegravir, ritonavir, combination antiretroviral products) |
| chemotherapeutic agents, oral (excluding hormonal agents) (e.g., cyclophosphamide, mercaptopurine, temozolomide) |
| hypoglycemic agents, oral |
| immunosuppressant agents (e.g., azaTHIOprine, cycloSPORINE, tacrolimus) |
| insulin, all formulations |
| opioids, all formulations |
| pediatric liquid medications that require measurement |
| pregnancy category X drugs (e.g., bosentan, ISOtretinoin) |

| Specific Medications |
|---|
| carBAMazepine |
| chloral hydrate liquid, for sedation of children |
| heparin, including unfractionated and low molecular weight heparin |
| metFORMIN |
| methotrexate, non-oncologic use |
| midazolam liquid, for sedation of children |
| propylthiouracil |
| warfarin |

# CENTERS FOR YOUTH AND FAMILIES

| Policy/Number | Chapter 61 | Clinical Supervision Policy | |
|---|---|---|---|
| | | | |
| Effective Date | June 2017 | | |
| Expiration Date | June 2019 | | |
| | This policy is reviewed every 2 years. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Clinical Operations Director | | |
| | Medical Director | | |

**Policy:** Clinical supervision will be provided to mental health professionals and mental health paraprofessionals to ensure quality treatment, excellence in documentation, and to meet licensure/board requirements of clinicians and Medicaid, Division of Behavioral Health regulations.

**Purpose:** To outline the clinical supervision process at Centers.

**Oversight:** The Medical Director and Clinical Operations Director are responsible for the oversight of clinical delivery of services.

**Clinical Supervisors:** Clinical supervisors will be selected based on competence in diagnosis, assessment, and mental health treatment of children and adolescents. Clinical supervision will be provided to mental health professionals and mental health paraprofessionals that is consistent with their respective licensure/certification requirements.

**Role of the Medical Director and Clinical Operations Director:** The Medical Director and Clinical Operations Director provide clinical supervision to program managers who provide occasional clinical services (e.g., emergencies, clinical staff coverage, overflow). Supervision is interactive and on going as needed and may be telephonic or in person.

**Specialty Supervisors:** In specific instances, a clinician may also receive supervision from a Specialty Supervisor.

**Supervision Process:** Documented client-specific face-to-face communication regarding client care will occur between each clinical supervisor and the clinician at least every ninety (90) calendar days. Clinical supervision may occur in group or in individual sessions. Supervision of mental health professionals will include each of the following at least every twelve (1) months:

1. Assessment and referral skills, including the accuracy of assessments;
2. Appropriateness of treatment or service interventions in relation to the client needs;
3. Treatment/intervention effectiveness as reflected by the client meeting individual goals;
4. Issues of ethics, legal aspects of clinical practice, and professional standards;
5. The provision of feedback that enhances the skills of direct service personnel;
6. Clinical documentation issues identified through ongoing compliance review;
7. Cultural competency issues;
8. All areas noted as deficient or needing improvement.

Supervision of mental health paraprofessionals will include each of the following at least every six (6) months:

1. Assessment and referral skills, including the accuracy of assessments;
2. Appropriateness of treatment or service interventions in relation to the client needs;
3. Treatment/intervention effectiveness as reflected by the client meeting individual goals;
4. Issues of ethics, legal aspects of clinical practice, and professional standards;
5. The provision of feedback that enhances the skills of direct service personnel;
6. Clinical documentation issues identified through ongoing compliance review;

7. Cultural competency issues;
8. All areas noted as deficient or needing improvement.

Mental health paraprofessionals will have a face-to-face contact with a mental health professional at least every fourteen (14) days. The MHPP will have at least twelve (12) face-to-face contacts every ninety (90) days.

**Action Plan:** If a problem is identified, the clinical supervisor involves the administrative supervisor. The administrative supervisor and clinical supervisor will meet to discuss the problem; and an action plan will be developed.

**Documentation of Supervision:** Clinical supervisors will document all supervisory sessions on agency supervision forms and maintain in a confidential file in a locked cabinet. Documentation of supervision will also be kept in the personnel files of the mental health professional and mental health paraprofessional.

**CENTERS FOR YOUTH AND FAMILIES ~ DOCUMENTATION ACTION PLAN**

Clinician:_____ Case #'s:_____

I. Describe specific problems with documentation:

_____

_____

_____

II. Training to be provided and by whom:

_____

_____

_____

III. Supervision Plan:

_____

_____

_____

IV. Goal/Outcome of Training and Supervision:

_____

_____

_____

V. Date to be Corrected:_____

VI. Role of Program Manager:

_____

_____

_____

VII. Role of Clinical Supervisor:

_____

_____

_____

_____ _____ _____

Signature of Program Manager Date Signature of Clinical Supervisor

**CENTERS FOR YOUTH AND FAMILIES**

| Plan/Number | ORG-19 | Staff Development Plan | |
|---|---|---|---|
| | | | |
| Effective Date | May 2018 | | |
| Expiration Date | May 2019 | | |
| | This plan is reviewed annually. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Director of Risk Management | | |
| | CFO/Chief Administrative Services Officer | | |
| | Chief Clinical Officer | | |
| | Chief Executive Officer | | |

I. Overview

***The Centers*** seeks to ensure that employees are provided with opportunities to develop, maintain, and improve their job knowledge, skills, and abilities. Training represents an investment of time and money in each employee. Each employee is required to obtain the number of training hours as determined by the licensing agency of the department/division, plus other training sessions based on an identified training need (a minimum of 30 hours for direct care and a minimum of 10 hours for support staff).

Requests for participation in job-related conferences, workshops, or training programs outside the facility may be made in advance by submitting a training request form to the Program/Administrative Manager. Approval will be based on availability of funds, agency needs, and impact of absence on provision of services. The regular pay of the staff member will be continued for any employee whose attendance at a training program, conference, or workshop is required by the agency.

Relias Learning is a web-based learning management system used by Centers for Youth and Families to provide required and optional training to staff on an individual basis.

II. Staff Development Planning

A multidisciplinary committee meets on a yearly basis to review the staff development plan and make suggestions for additions or deletions based on agency needs, changing regulations, and financial considerations.

A. This committee is facilitated by the CFO/Chief Administrative Services Officer.
B. Throughout the year, opportunities for training may be identified through performance improvement, risk management, and staff request.

III. Training Goals

The goals of training are as follows:

A. To keep current all required certifications, i.e., Behavior Management Program, CPR, First Aid
B. To keep staff abreast of current research, methods, or other information in their particular area;
C. To encourage staff to grow in knowledge and experience by offering opportunities for self-enhancing training;

D. To ensure that clients receive services in a safe environment.
E. To improve competency and knowledge based in specific areas pertinent to staff roles;
F. To ensure only medically necessary services are provided with proper documentation.

IV. Staff Development Opportunities

The following staff development opportunities are offered:

A. All Centers for Youth and Families staff
- New Employee Orientation which includes the following
  - The organization's mission and goals
  - Cultural diversity and sensitivity
  - Signs of abuse and neglect
  - Rights of clients and ethical aspects of care, treatment, and services and the process to address ethical issues
  - Code of ethics
  - Mandated reporting
  - Safety, body mechanics, infection control
  - Confidentiality
  - Equal Employment Opportunity
  - Corporate Compliance
  - Health Insurance Portability and Accountability Act
  - Relias Learning
  - Trauma-Informed Care
  - Therapeutic Boundaries
- Program Specific Orientation to include
  - Specific job duties and responsibilities
  - Service, setting, or program-specific job duties and responsibilities related to safety and infection control
  - Incident reporting/Unanticipated adverse events
  - Road test if staff is to transport clients
  - When job duties or responsibilities change, training specific to changed duties/responsibilities occurs

B. QBHP, Education Therapist, Nursing Staff

**Agency Orientation**
- QBHP - 40 hours
- Suicide Prevention and Intervention
- Human Trafficking
- Developmental Milestones
- Behavior Management Program to include underlying causes of threatening behavior; aggressive behaviors related to medical conditions; staff effect on client behavior; recognizing and interpreting signs of physical distress in clients who are being held or secluded; recognizing the effect of age, developmental level, gender, ethnicity and history of abuse; the correct use of time-out protocols. (Competency assessment to include written tests to be placed in each staff member's staff development file)
- CPR and First Aid

**Program Orientation**
- Behavior management and point/level systems
- Progress Reporting
- Sexual Adjustment as required by program/unit
- Driver Training
- Additional educational requirements for nursing:
  - Documentation (department orientation)
  - Nursing interventions to DSM V (department orientation)
  - Nursing interventions related to the developmental stage of children and

adolescents (department orientation)

C. Supervisors & Managers

**Agency Orientation**

- Agency policies - Human Resources (e.g., legal issues, CYF Personnel policies and procedures)
- Human Trafficking
- Developmental Milestones
- Behavior Management Program (clinical programs only) to include underlying causes of threatening behavior; aggressive behaviors related to medical conditions; staff effect on client behavior; recognizing and interpreting signs of physical distress in clients who are being held or secluded; recognizing the effect of age, developmental level, gender, ethnicity and history of abuse; the correct use of time-out protocols. (Competency assessment to include written tests to be placed in each staff member's staff development file).
- CPR and First Aid

**Program Orientation**

- Behavior management and point/level system (clinical programs only) to be presented as a part of program orientation

D. Clinical

**Agency Orientation**

- Behavior Management Program to include underlying causes of threatening behavior; aggressive behaviors related to medical conditions; staff effect on client behavior; recognizing and interpreting signs of physical distress in clients who are being held or secluded; recognizing the effect of age, developmental level, gender, ethnicity and history of abuse; the correct use of time-out protocols. (Competency assessment to include written tests to be placed in each staff member's staff development file)
- Human Trafficking
- Developmental Milestones
- CPR and First Aid

**Program Orientation**

- Clinical Orientation
- Treatment Planning Process
- Behavior management and point/level systems
- DSM-V (annually) to include multi diagnosis and Rule Out criteria
- Appropriate interventions per diagnosis
- Unanticipated adverse events
- Documentation requirements and legalities
- Substance abuse issues
- Sexual abuse issues
- Medications used for various disorders and side-effects
- Foster care and adoption issues
- Play Therapy or Theraplay - as designated by supervisor
- Group Therapy – as designated by supervisor
- Opportunities for clinical training at Clinicians' meetings
- Monthly modules for new clinicians (as needed)

E. Dietary, Housekeeping, Maintenance

**Program Orientation**

- Regular training by the Facilities Manager for housekeeping staff on the use of chemicals, proper cleaning methods, OSHA regulations, etc.
- Regular training by the Facilities Manager for maintenance staff on issues related to proper maintenance of facilities and equipment

V. Required Refresher Training

Specific refresher training is required of all staff, and additional refresher training of certain staff depending on their job responsibilities. The table below outlines this required training. Staff may be suspended without pay if training is not completed in a timely fashion.

| Training | Staff required to complete it | Format of training | Schedule |
|---|---|---|---|
| Behavior Management Program | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Presentation by staff development trainer with competencies assessed at the end of session - tests filed in individual staff development files | Every six months<br><br>TFHP – annual |
| CPR and First Aid | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Presentation by staff development trainer with competencies assessed throughout the session | Annually<br><br>TFHP – Every 2 years |
| Corporate Compliance including a conflict of interest statement | All staff of The Centers | Relias Learning; Conflict of Interest Statement signed at the conclusion of each fiscal year | Upon hire and annually thereafter |
| Incident Reporting/ Unanticipated Adverse Events | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Relias Learning | Annually on Relias Learning |
| Suicide Prevention and Intervention Refresher | QBHP<br>Education Therapist<br>Nursing Staff<br>Clinicians<br>Supervisors/Managers in clinical programs | Presentation by staff development trainer | Upon hire and annually |

VI. Tracking

A. The Risk Management Department is responsible for tracking all staff development hours of staff.

1. Staff compliance with number of required hours is addressed by the supervisor during the annual performance evaluation process.
2. Staff failing to complete required training may be suspended without pay until such time as the training is successfully completed.

# Centers for Youth and Families

| Policy/Number | Chapter 34 | Fiscal Policy | |
|---|---|---|---|
| | | | |
| Effective Date | June 2018 | | |
| Expiration Date | June 2021 | | |
| | This policy is reviewed every 3 years. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Chief Financial Officer | | |
| | Chief Operations Officer | | |
| | Chief Executive Officer | | |
| | Operations Chair | | |

I. **INTRODUCTION:** The Board of Directors (the Board) of Centers for Youth and Families (the agency) is responsible for governing the delivery and management of all services provided by the Agency. Furthermore, the Board is accountable to the general public and to the various funding sources for the allocation and use of its financial resources.

The Board provides the following fiscal policies to:

A. Govern the fiscal affairs of the Agency;
B. Assure reasonable and prudent management and accountability of its financial resources;
C. Communicate the basic fiscal structure of the Agency to its staff, contracting agencies, and funding sources;
D. Facilitate the management of the Agency by setting forth a structure within which operational procedures may be developed as needed.

II. **FISCAL YEAR**

A. The Agency fiscal year shall be from July 1 - June 30. The fiscal year shall be the time period upon which annual budgets shall be based with expenditures recorded against that budget for said time period.
B. Audits of Agency expenditures and records shall be conducted annually and completed and approved no later than October 31 for the previous fiscal year ending June 30.
C. These fiscal policies shall be reviewed prior to the start of the fiscal year. Any amendment or revision of fiscal policies shall take effect at the beginning of the fiscal year on July 1, unless otherwise specified.
D. Other fiscal decisions of the Board, such as the selection of an auditing firm, bank, etc., shall be made no later than June 1, to take effect July 1.

III. **ANNUAL BUDGET**

A. The Operations Committee, upon recommendation of the Agency's Chief Executive Officer, shall present an annual budget to the Board. The Board shall adopt the annual budget at its regular meeting in June of each year to take effect on July 1. The annual budget is defined as an operational plan for the Agency that contains projections by source of revenues to be collected, amounts established to be expended for general purposes, and goals to be accomplished with financial resources. Additional criteria may be established for the annual budget and information to be included in the budget.
B. The enacted annual budget shall comply with the requirements and regulations of the various funding sources to which the Agency is accountable.

D. The Board may amend the annual budget upon the recommendation of the Operations Committee.

E. The Chief Executive Officer may revise the amount budgeted for any general category up to 10% above that amount budgeted, except that the total budgeted for all expenditures shall not be exceeded without Board approval.

F. Upon the Board's approval of funding proposals and the funding sources' acceptance of the proposal, the annual budget is thereby amended accordingly. However, should changes occur between the proposal approved and that accepted, such changes shall be approved by the Operations Committee, taking into consideration Board approved priorities.

G. The Board may establish priorities for expenditures approved in the annual budget contingent upon the receipt of adequate revenues. In the event that revenues collected are below those revenues anticipated for the highest priority, the Chief Executive Officer shall institute necessary procedures to assure that expenditures do not exceed revenues.

## IV. PERSONNEL FUNDING

A. The Chief Executive Officer may create positions and establish salaries according to the needs of the Agency and the amount budgeted for personnel in the annual budget.

B. Agency employees shall receive compensation every two weeks on the basis of their effective annual salary as established. However, no payroll check shall be issued to any hourly employee who has not submitted a completed and signed payroll time report or entered his/her hours worked in the time clock system for that pay period, and had such report also signed by his/her immediate supervisor. Exempt personnel must complete a time report only when using leave.

C. The Chief Executive Officer shall designate fringe benefits to be provided Agency employees, according to the adopted personnel budget, except that such benefits shall not exceed the amount budgeted for Fringe Benefits in the annual budget.

D. The Chief Executive Officer, upon recommendation of the Chief Operating Officer shall select such providers based on those criteria.

## V. TRAVEL

A. Agency employees utilizing personal motor vehicles in the conduct of Agency affairs shall be reimbursed at the rate approved. This rate may be modified by Board action at any Board meeting. Reimbursement shall be based on official miles driven as calculated using mapquest.com for the shortest distances and the Agency shall not assume responsibility whatsoever for any maintenance, operational cost, accidents, or fines incurred by the owner of the vehicle while on official business for the Agency. Where more than one employee is transported in the same vehicle, only the owner shall be entitled to mileage reimbursement. Since employees are sometimes required to transport clients in their personal vehicles, the Agency shall provide liability insurance for such vehicle use. Mileage reimbursement will be made only during the month in which the travel occurred. Employees will not be allowed to report mileage for previous months unless approved by the Chief Financial Officer.

B. Agency employees shall not receive reimbursement for meals and lodging when traveling on official in-region business, except if an employee is required to attend meetings within the region, which includes meals, he/she is eligible for reimbursement of the cost of such meals. In-region Travel shall be defined as travel within Pulaski County or Drew County, as applicable.

C. Agency employees traveling Out-of-the-region (defined as any area not included as In-region) shall receive a per diem of $35 per day. Requests for reimbursement for transportation and lodging must be supported by proper documentation. The Chief Executive Officer or designee, upon presentation of appropriate documentation, may approve all or part of any additional costs. An additional $15 per day will be allowed for out-of-state travel.

D. Agency employees may also receive reimbursement for expenses incurred in attending conferences, seminars, etc. defined as Staff Development provided such attendance is in

accordance with their approved staff development plan.

E. Requests for reimbursement of travel expenses must be certified by the Agency employee requesting such reimbursement and the employee's Program Manager/Department Head.

F. Agency employees may receive an advance equivalent to the employee's anticipated expenses for approved out-of-the-region travel; provided, however, that (1) a check request is submitted to the Accounting Department at least ten business days prior to departure, and (2) the report of such expenses incurred be submitted to the Accounting Department within three working days upon the employee's return. Such report shall include repayment of any excess advance received above actual expenses. At the discretion of the Accounting Department, a P-card may be issued on a temporary basis in lieu of paying an advance.

G. The Chief Executive Officer, or designee, shall establish procedures for the use of Agency owned vehicles that as a minimum prohibits their use on personal business.

H. Board members shall be reimbursed upon request for expenses incurred in carrying out the Board's business, including reimbursement for travel costs to Board and board committee Meetings. The above policies applying to employees shall also apply to Board members. Any disputed claim or request regarding a Board member shall be referred to the Executive Committee of the Board, which shall approve or disapprove such claims or requests.

## VI. PETTY CASH FUND

A. A Petty Cash Fund up to the amount of $150.00 may be maintained by each office for incidental expenses. Receipts for all expenses from such Petty Cash Fund must be maintained and submitted to the Accounting Department at intervals no greater than monthly. The Chief Financial Officer or designee shall designate a custodian of the Petty Cash Fund for each office requesting such a fund. Exceptions to the above amount may be granted with a written request and approved by the Chief Executive Officer or Chief Financial Officer.

B. Only expenditures for Agency purposes may be made from this fund. The Chief Financial Officer or designee will conduct audits of all Petty Cash Funds at least quarterly.

## VII. PURCHASING

A. An executed purchase order shall be required prior to the incurrence of any Agency expenditure in excess of $25.00 not previously provided for (i.e., personnel, fringe benefits, travel, petty cash), except that recurring monthly expenses for utilities, telephone, and rent shall be approved by the Chief Executive Officer, Chief Operating Officer or Chief Financial Officer upon receipt of such billing. Purchases below $25.00 can be made from Petty Cash with appropriate receipts.

B. Purchase orders must be approved by one of the following: The Program Manager/Department Head, Chief Financial Officer, Chief Operating Officer, or the Chief Executive Officer.

C. All purchase orders in excess of $500.00 must be approved by the Chief Financial Officer, Chief Operating Officer, Chief Executive Officer.

D. Agency employees who are required to incur non-travel expenses for the Agency from personal funds shall be reimbursed for such expenses. The conditions for reimbursement shall be documentation of any expenses incurred from personal funds and an executed check request.

E. Management will consider the quality, price, fit for stated purpose, delivery time, and other generally accepted business standards when contracting for services to be provided.

F. Blanket purchase orders may be issued to the vendors to whom purchases are made on a recurring regular basis up to a maximum of $10,000.00. Blanket purchase orders may also be issued to vendors with whom the Agency has a contractual agreement to provide goods or services up to the amount of that contract for the current fiscal year.

G. No expenditure may be made, except as otherwise provided within this section, without a purchase order and proof of receipt of the approved services or goods and appropriate budget authorization.

## VIII. BUDGET VARIANCE

A. Variances in budgeted line items 10% and/or $1,000.00 over budget (per monthly financial statements) will require justification.

B. The responsible Program Manager/ Department Head will present an explanation for the budget variance to the Chief Financial Officer, to include:
   1. Reason for expenditure over budget
   2. Plan of correction

C. The Chief Financial Officer will review the documentation with the Program Manager/Department Head, provide feedback, and assist in the implementation of the corrective action plan.

D. Chief Financial Officer will discuss corrective action plans with the Chief Operating Officer and Chief Executive Officer.

## IX. BANKING SERVICES

A. Management shall evaluate at least every three years the bank and/or other financial institutions in which Agency funds are deposited and inform the Operations Committee of any recommended changes. At that time, criteria will be determine for selecting depositories and determine if a change is deemed appropriate. Based upon those criteria, the Chief Financial Officer shall recommend a bank and/or financial institutions for the upcoming fiscal year, with such selection to be approved by the Operations Committee, no later than July 1.

B. To be eligible, a banking institution must meet the following criteria:
   1. The banking institution must be chartered by the federal or state government and be a part of all relevant federal insurance plans;
   2. The banking institution must have convenient, full-service locations;
   3. The banking institution must provide all of the services being sought by the Agency in its requests for proposals.

C. The bank must be capable of, and agree to, provide full banking services. There may or may not be a service charge for these services depending upon interest earned on these funds. These services shall include, but not be limited to, the following:
   1. Accepting deposits and processing checks. Reconciliations will be furnished on computer tapes for the Agency's combined account, its payroll account, and possibly additional accounts in the future, if desired;
   2. Complete wire transfers, night depository services, investment services, coin sorting, and counting services;
   3. Provide the Agency a monthly statement that details daily account balances, average interest rate applied, and the dollar amount of interest credited various Agency accounts.

D. The minimum level of cash maintained in Agency accounts should be sufficient to meet the current cash operating needs.

E. All checks issued to be drawn on Agency checking accounts must be signed by two of the following:
   1. Chief Executive Officer
   2. Chief Financial Officer
   3. Chief Operating Officer

F. The Chief Executive Officer, Chief Financial Officer, Chief Operating Officer or their designee may transfer funds between Agency accounts.

G. The Chief Executive Officer, Chief Financial Officer or Chief Operating Officer may establish a line of credit to assist the Agency in meeting cash flow requirements. The Operations Committee will be informed each time the line of credit is used.

## X. FACILITIES

A. No facility may be purchased, or any obligation to purchase, with Agency funds without the expressed approval of the Board.

B. No facility may be purchased or acquired through a lease-purchase agreement with Agency funds whereby the title, or control of such facility, rests with any entity other than the Agency.

C. All facilities rented by the agency shall be on the basis of a "lease agreement" or "letter of understanding" that, at a minimum, contains the description of property rented, number of square feet, square foot cost, monthly cost, provision for utilities, janitorial service, and risk protection, and effective dates of the agreement that is signed by the owner, or his agent, of the facility and the Chief Executive Officer, Chief Operating Officer or designee.

## XI. INSURANCE

The agency will have appropriate Insurance coverage to protect the agency's human, fiscal, and physical assets.

A. The Chief Executive Officer or Chief Operating Officer shall obtain insurance for:
   1. All Agency-owned property (or property leased for which the Agency bears a risk);
   2. Premises liability coverage at each facility operated by the Agency;
   3. Professional Liability:
   4. Volunteer Liability;
   5. Bonding Protection;
   6. Non-Owned Vehicle Liability;
   7. Worker's Compensation;
   8. Director's and Officer's Liability; and
   9. Other protection as recommended by the Chief Executive Officer or the Chief Operating Officer. The Operations Committee shall establish the limits of insurance to be obtained and the criteria for selecting provider.

B. Insurance coverage shall be reviewed annually.

C. Any Agency owned property that is being used for another entity shall be insured for property and premises liability by that entity.

D. The Agency will seek bids on its insurance coverage at least every three years. The agency may request insurance coverage bids more frequently than three years should the Agency experience unsatisfactory service or large rate increases.

## XII. EQUIPMENT

A. No equipment may be purchased by Agency funds whereby the ownership of such equipment rests with any entity other than the Agency.

B. The Agency shall maintain an inventory of all equipment owned by the Agency with a purchase value of $1,000.00 or more. The Chief Financial Officer shall designate a person at each facility, where Agency equipment is assigned, as custodian of the assigned equipment.

C. An audit of the equipment inventory shall be conducted annually by Chief Financial Officer or designee.

D. When the rental or lease of equipment is determined to be more economical than the purchase of equipment, or when adequate funds are not budgeted for the purchase of equipment, the Chief Financial Officer may enter into the most cost-effective rental agreement for such equipment.

## XIII. AUDITS

A. A financial audit of the Agency shall be conducted annually, no later than October 31, for the preceding fiscal year.

B. The Board shall select an auditing firm, upon the recommendation of the Operations Committee. The Operations Committee shall establish the criteria for selection of the auditing firm and evaluate that selection annually, no later than April 1.

C. Copies of the audits shall be provided to the Board by its regular October meeting.

D. The Chief Executive Officer shall take necessary steps to correct any deficiency identified by the auditors.

E. The financial audit shall be conducted according to generally accepted auditing standards for non-profit organizations. Such audit, as a minimum, shall: 1) evaluate the Agency accounting system's internal control measures; 2) obtain sufficient competent evidential matter to afford a reasonable basis for an opinion on the financial statements; 3) examine the financial statements for accordance with generally accepted accounting principles; and 4) make such other examinations as the Operations Committee or auditing firm deems appropriate.

F. A written report of all audits shall be provided to the Board at the meeting following receipt of the audit report.

## XIV. CONTRACTS

A. The Chief Executive Officer, Chief Operating Officer or Chief Financial Officer may approve a contract between the Agency and another party to secure or obligate services, according to the Board approved budget and priorities.

B. Prior to the approval of any contract for services, an analysis of the cost of contracting versus employing the person, the criteria for obtaining of the services, and alternatives be considered.

C. Contracts, as a minimum, must contain the approval of the Chief Executive Officer, Chief Operating Officer or designee and the other contracting party, dates, services to be provided, compensation, and person in Agency responsible for the contract.

D. Contracts with agencies for purchase of direct services must be reviewed and approved annually.

E. No compensation may be issued to any contracting party for services that have not been delivered or when proper reports of delivered services, as provided by the Agency, have not been received.

F. All contracts shall remain on file with the Chief Financial Officer or designee for a period of 36 months following fulfillment of all conditions contained therein.

## XV. FISCAL PROCEDURES

A. The Agency accounting system shall be on the basis of generally accepted accounting principles.

B. Fees charged for services shall be on the basis of a fee schedule approved by the Chief Executive Officer. No services may be delivered at a lower cost than as provided on the fee schedule without the approval of the Chief Executive Officer or his designee.

C. A list of Accounts Receivable shall be compiled monthly and statements rendered on all outstanding accounts. The process of collecting bad debts should be an administrative process with the decision being made by the Chief Financial Officer as how to pursue collection.

D. Fees for services provided but not paid for at the time of service shall be charged as an account receivable.

E. All money received at any Agency office shall be deposited intact in Agency-approved accounts.

F. The Chief Financial Officer shall submit a monthly financial report to the Operations Committee no later than the date of the monthly meeting. The Operations Committee may determine the format and information to be contained in such a report.

G. The Chief Financial Officer shall develop and maintain an accounting system that

classifies revenues by source and expenditures by function and services.

H. Items identified in the annual budget as equipment with a cost of $1,000 or more, and a useful life of more than one year, shall be capitalized as Agency assets and depreciated monthly according to the straight-line depreciation method. The guidelines of the Internal Revenue Service shall be used in the determination of useful life.

I. Building improvements with a cost of $1,000 or more shall be capitalized as a part of the cost of such building and depreciated according to the useful life of the building.

J. In the event that a source of revenue is conditional upon a percentage of such revenue being matched through a donor party, only the net revenue received shall be reported as income to the Agency. (A sub-ledger shall be maintained on all match funds provided by a donor party so that the amount remaining in each donor account can be readily determined).

K. The funds and expenditures which are the matching funds for grants or contracts which require matching funds to be reported by the Agency, but not paid to any donor party or funding source, shall be clearly identified.

## XVI. ADMINISTRATION

A. The Chief Executive Officer, with the advice of the Chief Operating Officer and the Chief Financial Officer, shall be responsible for the interpretation, implementation, and administration of these fiscal policies. He shall issue any procedures or regulations necessary to carry out these policies. He may delegate authority to implement these policies, procedures or regulations.

B. The Agency shall comply with any fiscal regulations or rules promulgated by any funding source, except that if such rule or regulation is in conflict with these fiscal policies, or any other Board policy, the Operations Committee shall recommend appropriate action to the Board.

C. Anytime a component of the organization receiving designated gifts or monies from the public, resulting in excess revenues at year-end, the transfer of funds to other components would be from sources other than gift funds.

## XVII. INVESTMENT OF IDLE FUNDS

A. The overall investment procedures, established by management and approved by the Board of Directors, shall maintain needed liquidity, avoid risk, and maximize returns. The following are approved types of investments:

Demand Deposit Accounts - includes passbook savings, statement savings, and money market savings accounts.

Time Deposit Accounts - Certificates of Deposit that require the deposit remain at the institution for a specified period of time.

U.S. Government Obligations - includes Treasury notes and bills issued by the U.S. Government.

B. Authorization of Investment Vehicles

The Operations Committee of the Board of Directors shall authorize the use of specific depository and investment banks and brokerage firms. This authorization shall be documented in the minutes of the Operations Committee meeting and communicated to management. As part of the authorization process, management shall evaluate the Agency's prior relationship with banks and brokerage firms to determine suitability for renewal. Such evaluation should consider service responsiveness, types of investments offered, quality of investment advice, service and transaction charges, and any other relevant criteria.

C. Authorization of Investments

The Chief Executive Officer, Chief Operating Officer, or Chief Financial Officer shall approve investment of funds for periods of time not to exceed 1 year. The Operations Committee shall approve all investments for periods of time greater than 1 year. All transactions regarding investments shall be properly authorized by the Chief Executive Officer, Chief Operating Officer or Chief Financial Officer such as movement to and from safekeeping assets through use of a vault or safe deposit box. Investments purchases shall be made by check or bank transfer.

D. Reconciliation of Investment Accounts

Investment account balances shall be reconciled regularly with the general ledger balance. Such reconciliation shall be reviewed and approved by the Chief Financial Officer.

All investments shall be properly controlled to safeguard against theft, misuses, loss, or damage. Certificates and other investment documents shall be properly controlled by authorized personnel, bankers and/or brokers. Storage shall be kept in the Company's bank safety deposit box.

Should certificates be kept temporarily on the Agency's premises, the certificates shall be kept in a locked, fireproof safe. If a safe is not available, a locked file cabinet shall be utilized for temporary storage.

E. Receipt of Corporate Stocks

It shall be Agency policy, unless prohibited by donor which prohibition shall be approved by Operations Committee, to sell all stock contributions to the Agency immediately upon receipt of the stock. Disposition of the stocks will be handled by the Centers' authorized agent.

# CENTERS FOR YOUTH AND FAMILIES

| Policy/Number | Chapter 44 | Client Records Policy | |
|---|---|---|---|
| | | | |
| Effective Date | January 2019 | | |
| Expiration Date | January 2020 | | |
| | This policy is reviewed annually. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Client Records Coordinator | | |
| | Medical Director | | |
| | Chief Clinical Officer | | |
| | Operations Committee, Chair | | |

**Purpose:** The purpose of this policy is to ensure as much as possible that a complete chronological record of each client's episodes of care are documented in a timely accurate manner.

**Policy:** A client record will be maintained for each client from the day of admission to the day of discharge from The Centers and for 10 years after the child has reached the age of 18.

**Procedures:**

**Access to the Client Record**

In order to ensure the security and confidentiality of the client record, the Centers for Youth and Families has outlined the following guidelines relating to chart access. The extent of access shall be determined in accordance with The Centers' Privacy Plan.

A. Medical Director, Chief Clinical Officer, Client Records Coordinator have unlimited access in accordance with the Centers' Privacy Plan.

B. Medical/Clinical Staff (clinicians, nurses, physicians, Advanced Practice Registered Nurse, MHT's,etc.)
   1. Have access to the client record of any client for whom they are providing services.
   2. Do not by virtue of their position/licensure have access to any chart for which they are not providing services.

C. Administrative Support Staff (unit secretaries, etc.)
   1. Have access to the client record only in the performance of their assigned duties.

D. Clients 18 years of age or older
   1. Have access to their record after proof of identity has been established.

E. Legal Guardian/Custodian
   1. Has access to the client record while the child is age 17 or younger.
   2. Access ends with the child reaching age 18.

F. Divorced Parent with Full Custody of Client
   1. Have access to the client record while the child is age 17 or younger.
   2. Access ends with the child reaching age 18.

G. Divorced Parent without Custody
   1. Do not have access to the client record unless
      - There is a release of information from the custodial parent on file
      - There is a copy of a fully executed divorce decree on file that specifically provides for the non-custodial parent to have access to the records
   2. If the non-custodial parent is providing payment for services he/she does have access to billing information.

H. Divorced Parents with Joint Custody
   1. Have access while the client is 17 or younger.
   2. Access ends with the child reaching age 18.

I. Department of Human Services
   1. Have access if the state has legal custody of the client.
   2. Access ends with the child reaching age 18 unless there is a signed release of information or until the age of 21 if the client remains in DCFS custody.

J. Law Enforcement
   1. Access to client record for legitimate law enforcement inquiry only; otherwise no access without a current signed authorization from client, legal guardian or court order/subpoena

K. Military Recruiters
   1. No access to client record without a current signed authorization from client, legal guardian or court order/subpoena.

L. Lawyers
   1. No access to client record without a current signed authorization from client, legal guardian or court order/subpoena.

M. Schools
   1. No access to any information other than school-related in the client record without a current signed authorization from client, legal guardian or court order/subpoena.

N. If at any time the client, legal guardian or other non-staff persons are permitted to view the client record, (excludes authorized outside auditing entities) the viewing shall be done in the presence of a staff member of the Centers for Youth and Families.

**Protection of Client Information Deemed to be of a Sensitive Nature**

A. When certain portions of the client record are deemed to be so confidential that extraordinary means become necessary to preserve client confidentiality the following process shall be followed:
   1. Situations where the confidentiality of the entire chart is required:
      - The Client Records Coordinator shall be notified.
      - In these cases the client will be assigned an "alias" which will be issued by the Client Records Coordinator.
      - A register listing all "alias" names shall be maintained in a secure place in the Client Record Department. The register shall list the alias as well as the actual name of the client to whom the name was assigned.
      - All charting documentation and correspondence relating to the client shall reflect the "alias" name to include the electronic information system.
   2. Situations in which only selected portions of the client record require confidentiality, such as a diagnosis of HIV positive or HIV testing:
      - The Client Records Coordinator shall be notified by the Program Manager if any HIV testing has been done or the client has a diagnosis of HIV positive.
   3. The Arkansas Department of Health must receive reports of any client newly determined to have AIDS or to have tested positive for HIV, in accordance with Ark. Code Ann. 20-15-905 and 20-15-906.

**Safeguarding Against Destruction**

The Client Record Department has back-up copies of records on CD ROM disks. These back-ups are stored at a separate site from the department and the building which houses the department.

**Uniform Data Definitions**

In order to ensure the uniformity of information captured in the client record, approval for the use of forms in the EMR must be reviewed and approved by the Client Record Committee who is responsible for monitoring and maintaining uniform data elements.

**Clinical Record Reviews**

A. Quantitative Chart Reviews
   1. Monthly each program area will conduct a quantitative chart review.
   2. Data reported will be de-identified.
   3. Reviews will be submitted to the Client Records Coordinator who shall prepare reports to the Medical Director, Chief Clinical Officer and Program Managers, which reflect results of each month's review as well as trending data across a period of time. .

**Staff Training on Client Record Requirements**

A. It shall be the responsibility of Human Resources to ensure that new employees of the agency receive education concerning the contents of this policy.

B. This shall be done by presentations at each New Employee Orientation.

**Documentation Time Frame Requirements**

A. The Client Record Committee is responsible for both maintaining document time frames as well as monitoring for compliance as outlined in the clinical record review. Time frames for selected documentation are as follows:

1. **Initial Psychiatric Diagnostic Assessment**

| | |
|---|---|
| Residential Units | 60 Hours of admission |
| OBHS Programs | Within 45 days of admission for Tier 2 and Tier 3 clients |

Completion of the Psychiatric for Tier 1 clients is not required but may be completed if indicated by the Physician/APN.

2. **Psychological Evaluations**

Not a mandatory evaluation in program areas. Evaluations are performed when required. Each program's treatment team submits a Psychological Evaluation Referral form to the Psychological Examiner.

3. **Mental Health Evaluation**

Initial

The requirement is a completed assessment within 24 hours of admission in all programs.

The format for the assessment, which is mandatory in all programs, has been developed and approved for use.

Must obtain physician signature on MHE/MHD and complete initial treatment plan section on MHE/MHD if client will be receiving services prior to completion of the MTP.

Re-Admission

Full MHE/MHD is required.

Transfers

When a client is the subject of a transfer, the receiving program shall review the assessment and prepare a full MHE/MHD based on current medical necessity and if there is a significant change in client status. Refer to Access/Transfer Plan (ORG-6).

Dual Programs

The MHE or MHD will be prepared by the first program to which client is admitted. When the client is admitted to a second program, the second program will make sure that the MHE or MHD contains current information and update the information in the EMR if necessary. The second program will also complete a progress note documenting the client's admission into the program. If a client is admitted to two programs at the same time, the most restrictive program will complete the MHE or MHD and the lesser restrictive program will complete a progress note documenting the client's admission to the second program.

4. **Master Treatment Plan**

Initial

| | |
|---|---|
| Residential Units | 7 Days of admission |
| OBHS Programs | 14 Days of admission |

Continuing Clients

Clients frequently continue receiving Centers' services for extended time periods. A Master Treatment Plan, as the individual plan of care, needs to be based on current problems, diagnoses, goals and objectives. .

Transfers
When a client is the subject of a transfer, the receiving program shall review the initial master treatment plan and prepare a treatment plan update based on current problems, diagnoses, goals and objectives for treatment. Residential programs are the exception to this policy. A new master treatment plan is always completed for residential.

Dual Programs
When a client is in more than one Centers program, the most restrictive program prepares the master treatment plan or update.

5. **Treatment Plan Reviews**

| | |
|---|---|
| Residential Units | 30 Days |
| OBHS Programs | 6 months |

6. **OBHS Services**

The following documentation is also required according to Medicaid regulations for all clients in all programs except residential:

1. A client can receive 3 Counseling Level services (Tier 1) before a PCP referral is required. The PCP referral is not required for client in Tier 2 and Tier 3.
2. OBHS Psychiatric Assessment – Face to face assessment completed by the physician/APN within 45 days of admission to verify medical necessity for behavioral health treatment for client in Tier 2 and Tier 3. The Psychiatric Assessment must be updated every 12 months at a minimum. The Psychiatric Assessment is not required for clients receiving Counseling Level services (Tier 1) but may be completed if indicated by the physician/APN.

**Time Frames for Keeping Client Information after Discharge**

A. It is Centers' policy that client information once a client has been discharged from the agency be maintained for a period of 10 years after the client has reached the age of 18. Adult Clients for a period of 10 years from the discharge date.
   1. The Client Records Coordinator shall be responsible for selecting the methods to be used for ensuring that data are maintained and safeguarded against loss or destruction, i.e., CD ROM storage.

**The Clinical Record**

A. Medical record documentation shall be developed and maintained for each client who receives assessment and/or treatment in any component of the Centers For Youth & Families.
B. All documentation for each individual shall be assembled and located in one central record, unique to that client, thereby constituting a unit record.
C. Documentation with the unit record shall be maintained in a standardized format and arranged in a standardized sequence.
D. All documentation must be legible.

**Discharge Summaries**

Each client receiving treatment at the Centers shall have such treatment documented via the use of a discharge summary to be completed immediately upon discharge.

**Transfer**

If an individual is to be moved within the agency from one program or service area to another a Transition Discharge Summary will be completed. Refer to Access/Transfer and Utilization Management Plan (ORG-6) for transfer procedures and documentation.

**Completion of Records after Discharge or Transfer to a Different Level of Care**

A. At discharge/transfer the programs shall make sure all documents are signed, and all documents scanned into the EMR

B. It is the responsibility of the Client Record Committee to monitor compliance for transfer and discharge charts and recommend corrective action(s) to PIC when necessary.

**Authorization of and Authentication of Entries in the Client Record**

A. The physician/health care practitioner who treats a client shall have the responsibility for documenting and authenticating the care rendered. Such documentation shall be in accordance with:
   - generally accepted professional standards of documentation
   - specifically mandated regulatory, legal, and/or accreditation standards
   - documentation guidelines developed in concert with this policy and approved by the Client Record Committee

B. Proper authentication shall be added at the conclusion of each entry and shall consist of the practitioner's name, and initials indicating professional credential.

C. The use of rubber stamps for signatures in the client record is prohibited unless followed by a written signature.

D. No other individual (clerical or administrative staff) shall be authorized to delete, change, sign or authenticate material in the client record. This provision is not intended to prohibit assistance by administrative staff in preparing material for direct entry and authentication by a responsible practitioner or member of the medical staff, such as administrative staff assisting the family with consents for treatment.

**Miscellaneous Items**

**Standardized Abbreviations and Symbols**

A. In order to reduce error and foster clarity of written communication, only approved abbreviations and symbols shall be used in making data entries in the client record.

A. Each approved abbreviation and symbol shall have only one meaning.

C. The standardized abbreviations and symbols listing shall be approved by the Client Record Committee.

D. The approved list will be reviewed annually by the Client Record Committee. Refer to Appendix B.

E. A list of unapproved abbreviations is found in Appendix C.

**Client Chart Organization**

A. The client record content shall be placed in a standardized sequence within the record of each client in order to foster ease of access to the material for subsequent use.

B. Material placed in the client chart shall be filed/scanned in one of the following 12 index tabs
   - Admissions
   - Assessments
   - Behavior
   - Consents
   - Correspondence
   - Discharge
   - Education
   - External Information
   - Financial
   - Graphics
   - Laboratory
   - Legal
   - Medical
   - Physician's Orders
   - Progress Notes
   - Referral
   - Substance Abuse
   - Substance Abuse Treatment
   - Therapeutic Leave
   - Treatment Planning

- Wrap Around

C. Refer to Appendix A for Scanning (EMR)

**Forms**

A. The responsibility for form design and control shall rest with the Client Record Committee that:
   1. Shall include members of the administrative and direct client care departments as needed.
   2. The chairperson of the committee shall be the Client Records Coordinator.

B. The duties of the committee shall be to:
   1. review and approve all new forms
   2. periodically review and revise existing forms
   3. oversee the forms control process
   4. determine location of all new forms in the client record

**Use of Paper Forms**

It may from time to time be necessary to use paper forms because of the EMR being down for an extended period of time. In this case go to the "P" Drive and click on Client Record Forms. You will then be able to print out what is needed. If the "P" Drive is also down then contact the Client Records Department to obtain the required forms. The 24 hour programs will maintain a file with paper forms for those times when the Client Record Department is closed.

**Making Corrections in the Record**

Refer to Documentation of Service Provision Policy (Chapter 69)

**Actions to be Taken when Clinical Staff Leave the Agency**

A. Upon receipt of a letter of resignation from clinical staff the Program Manager will ensure that the following actions are taken:
   - an active client list is pulled from the EMR for the clinical staff
   - some action is taken to ensure that the client is either discharged or transferred to other clinical staff
   - if transferred to other staff a progress note must be made to that effect in the EMR
   - the Program Manager will make sure that the clinical staff has completed all EMR Documents before leaving the agency

**Faxing Client Information**

A. Internally
   1. When there is a need for internal transfer of client information, copies from the client record may be faxed.
   2. The staff member faxing internally must ensure that the information is received by the staff person authorized to receive it.
   3. Only the information necessary for the intended purpose may be faxed.

B. Externally
   1. No external faxing of client information is allowed in Centers' programs except for payment. For all other external faxing, the Client Records Coordinator must be contacted before taking any action.

C. When faxing, the following procedure must be followed:
   1. Complete an authorized transmittal cover sheet.
   2. Verify the telephone availability of the person authorized to receive the information before beginning the transaction.
   3. File the original facsimile cover sheet in the correspondence section of the client record noting what information was faxed.

**Release of Information**

The specific process for authorization to release information is outlined in Chapter 15 of the Centers' Policies and Procedures.

**Appendix A**
**FORMS FOR SCANNING (EMR)**

- Abnormal Involuntary Movement Scale (AIMS)-**MEDICAL**
- Academic Assessment –**EDUCATION**
- Acknowledgement of Receipt of Notice of Health Information Practices-**ADMISSIONS**
- Addendum to MTP-**TREATMENT PLANNING**
- Admission Information Checklist-**ADMISSIONS**
- Application for Block Grant Services (DHS-100) **-ADMISSIONS**
- Arkansas Medicaid Primary Care Physician Managed Care Referral Form-**REFERRAL**
- Assessment of Learning Needs-**EDUCATION**
- Authorization for Release of Protected Health Information-(for **Verbal Communication only these will be scanned into the CONSENTS** section and for release of PHI these go to Client Records. Once fulfilled they will then be scanned into the **CORRESPONDENCE** section **(once fulfilled, this authorization cannot be used again)**
- Beacon Health Authorization for Services – **ADMISSION**
- Behavior Checklist-**REFERRAL**
- Benefit Package Adjustment-**ADMISSIONS**
- Birth Certificate-**ADMISSIONS**
- Body Check-**MEDICAL**
- CDI (Children's Depression Inventory)-**ASSESSMENTS**
- Case Management Collateral Progress Note-**PROGRESS NOTES**
- Certificate of Need (Internal)-**ADMISSIONS**
- Certificate of Need (External-sent to us from BHO)-**ADMISSIONS**
- Change in RSPMI Primary Provider-**ADMISSIONS**
- Child & Adult Self Assessments-**ASSESSMENTS**
- Client Financial Agreement-**ADMISSIONS**
- Client Release to Police Officer – **LEGAL**
- Client Staffing-**TREATMENT PLANNING**
- Client Weekly Progress Report-**PROGRESS NOTES**
- Clothing Inventory **- ADMISSIONS**
- Conners-**ASSESSMENTS**
- Consent Forms-**CONSENTS**
  - Authorization to Photograph
  - Confidentiality Statement
  - Consent for Admission and Treatment
  - Consent for Transportation
  - Consent Form
  - Consent Form & MAR (Vaccine Administration Record)
  - Family Participation Contract
  - Informed Consent
  - Self Medication Facilitation
  - Treatment Participation Agreement
- Coping Plan-**TREATMENT PLANNING**
- Correspondence-**CORRESPONDENCE**
  (internal and external while a client at Centers
- Counseling Progress Notes-**PROGRESS NOTES**
- Crisis Intervention Assessment & Plan – **ASSESSMENTS**
- Court Orders-**LEGAL**
- Crisis Safety Plan-**TREATMENT PLANNING**
- Daily Summary**-PROGRESS NOTES**
- Demographic Sheet - **ASSESSMENTS**
- Diabetic Record-**MEDICAL**
- Diet Order Form-**MEDICAL**
- Discharge Agreement AMA-**DISCHARGE**
- Discharge/Pass Medication Form-**MEDICAL**

- Discharge 30 Day Agreement-**DISCHARGE**
- EBR Response-**MEDICAL**
- Educational Discharge Summary-**EDUCATION**
- Emergency Safety Intervention Reporting-**BEHAVIOR**
- Enuretic/Encopretic Flow Sheet **- GRAPHICS**
- ESI Notification to Parent or Guardian-**BEHAVIOR**
- Extended Day Form-**CORRESPONDENCE**
- External Medical Reports (done while a client at Centers)-**MEDICAL**
- Foster Home Agreement Addendum **– ADMISSION**
- Grades-**EDUCATION**
- Group Note-**PROGRESS NOTES**
- Health/Education Group Note-**PROGRESS NOTES**
- Health Screen-**MEDICAL**
- History & Physical-**MEDICAL**
- Home Visit Note-**PROGRESS NOTES**
- Hospital/Clinic Visit Form-**MEDICAL**
- Immunizations-**MEDICAL**
- Individual Behavior Protocol-**TREATMENT PLANNING**
- Individual Behavior Protocol: TPR-**TREATMENT PLANNING**
- Individual Behavior Protocol Signature Page-**TREATMENT PLANNING**
- Individual Therapy Progress Note-**PROGRESS NOTES**
- Initial Nursing Evaluation-**MEDICAL**
- Initial Psychiatric Diagnostic Assessment-**ASSESSMENTS**
- Lab Reports-**LAB**
- Meals Application **– ADMISSION**
- Medicaid Card (ARKids 1$^{st}$)-**ADMISSION**
- Medicaid Eligibility Verification-**ADMISSION**
- Medicaid Medication Informed Consent-**MEDICAL**
- Medicaid Number Check **– ADMISSION**
- Medical Progress Note-**MEDICAL**
- Medication Administration Record (MAR)-**GRAPHICS**
- Medication Change Letter-**MEDICAL**
- Medication Reconciliation-**MEDICAL**
- Medication Referral **- REFERRAL**
- Medication Refill-**MEDICAL**
- Medication Information Sheet (Informed Consent)-**CONSENTS**
- Medication Management Note-**MEDICAL**
- Medication Review and Education-**MEDICAL**
- Mental Health Evaluation-**ASSESSMENT**
- Night Monitoring Logs-**GRAPHICS**
- No Harm Contract-**TREATMENT PLANNING**
- Nursing Discharge/Transfer Form-**MEDICAL**
- Nutritional Assessment-**ASSESSMENTS**
- Nutritional Assessment Referral **- REFERRAL**
- Occupational Therapy Evaluation-**EXTERNAL INFORMATION**
- Outpatient Information for Inpatient Residential Referral-**REFERRAL**
- PACE Evaluations **– EXTERNAL INFORMATION**
- PCP Referral**-REFERRAL**
- PDA Continuing Care-**ASSESSMENTS**
- Pain Rating Scale-**MEDICAL**
- Parent/Guardian Notification (ESI)**-BEHAVIOR**
- Parent Rating Scale-**ASSESSMENTS**
- Pharmacologic Management Progress Note-**MEDICAL**
- Physicians Admission & Discharge Orders-**PHYSICIAN'S ORDERS**
- Physicians Orders-**PHYSICIAN'S ORDERS**

- Physician Order for Precautions-**PHYSICIAN'S ORDERS**
- Physician Order for ESI-**PHYSICIAN'S ORDERS**
- Physicians Report-**EDUCATION**
- Physicians Report for ADHD-**EDUCATION**
- Precautionary Status Observation Log-**PROGRESS NOTES**
- Private Insurance Authorization-**ADMISSIONS**
- Progress Note-**PROGRESS NOTES**
- Psychiatric Diagnostic Assessment (RSPMI)-**MEDICAL**
- Psychological Evaluation-**ASSESSMENTS**
- Psychological Addendum-**ASSESSMENTS**
- Psychological Referral**-REFERRAL**
- Psychotropic Safety Monitoring Flowsheet-**MEDICAL**
- RCMAS-**ASSESSMENTS**
- Rehab Day Summary-**PROGRESS NOTES**
- Request for Case Management Services-**REFERRAL**
- Request for PCP Authorization Services-**REFERRAL**
- Residential Dietary Flow Sheets – **GRAPHICS**
- Residential Nursing Discharge **– MEDICAL**
- Residential Nutritional Supplement Form – **GRAPHICS**
- Residential Shift Note-**PROGRESS NOTES**
- Residential Treatment Participation Agreement-**CONSENTS**
- Respite Care Referral-**REFERRAL**
- RSPMI Family Participation Contract**–CONSENTS**
- Safety Plans-**TREATMENT PLANNING**
- School District Referral-**REFERRAL**
- Screen for Physician Determination-**MEDICAL**
- Service Coordination Referral - **REFERRAL**
- Shelter Discharge/Aftercare Plan-**DISCHARGE**
- Shelter Initial Contact**-ADMISSIONS**
- Shelter Service Plan-**TREATMENT PLANNING**
- Shelter Shift Note**-PROGRESS NOTES**
- Social Security Card-**ADMISSIONS**
- Speech Evaluation-**ASSESSMENTS** (If done while a client is at Centers, if not, scan under) **EXTERNAL INFORMATION**
- Speech Therapy Notes (done while a client at Centers)**-PROGRESS NOTES**
- SPOE- **ASSESSMENTS**
- SPOE Foster Care Addendum **– ASSESSMENTS**
- Subpoenas**-LEGAL**
- Substance Abuse Assessment Referral-**REFERRAL**
- Suicide Risk Assessment-**ASSESSMENTS**
- Supplemental Treatment Plan-**TREATMENT PLANNING**
- TFHP Crisis Plan-**TREATMENT PLANNING**
- TFHP Initial Plan of Care-**TREATMENT PLANNING**
- TFHP Monthly Progress Report-**PROGRESS NOTE**
- TFHP Plan of Care Review-**TREATMENT PLANNING**
- TFHP Plan of Care Signature Sheet-**TREATMENT PLANNING**
- TFHP Safety and Supervision Plan-**TREATMENT PLANNING**
- TFHP Visitation Plan-**TREATMENT PLANNING**
- TTLC Shift Note**-PROGESS NOTES**
- Target Behavior Worksheet-**ASSESSMENTS**
- Teacher Rating Scale-**ASSESSMENTS**
- Therapeutic Foster Care Application-**REFERRAL**
- Therapeutic Leave Evaluation-**THERAPEUTIC LEAVE**
- Time Out Reporting-**PROGRESS NOTES**
- Transition Discharge Summary-**DISCHARGE**

- Treatment Participation Agreement-**CONSENTS**
- Treatment Plans-**TREATMENT PLANNING**
- Treatment Team Signature Sheet **–ATTACH TO RELEVANT TREATMENT PLAN**
- Tuition Agreement – **EDUCATION**
- Vaccine Administration Record **- MEDICAL**
- Vanderbilt Assessment**- ATTACH TO MENTAL HEALTH EVALUATION OR IF A LATER DATE SCAN UNDER ASSESSMENT**
- Visitors/Authorized Persons-**CORRESPONDENCE (at discharge)**
- Vital Sign Flow Sheet-**GRAPHICS (at discharge)**
- Vocational Screen-**ASSESSMENTS**
- Wraparound Plan of Services-**WRAPAROUND**
- Weekly Nursing Summary-**MEDICAL**
- Weekly Progress Note-**PROGRESS NOTE**
- Withdrawal Form – **EDUCATION**

## Appendix B
## Standard Abbreviations & Symbols

| | |
|---|---|
| Abdomen/abdominal | Abd |
| Absent without Leave | AWOL |
| Activities of Daily Living | ADL |
| Adjustment | adj |
| Administer | Admin |
| Admitting | Adm |
| Adolescent Day Treatment | ADT |
| As evidenced by | AEB |
| Auditory Hallucinations | AH |
| African American | AA |
| After Meals | p.c. |
| Against Medical Advice | AMA |
| Alternative Learning Center | ALC |
| Amount | Amt |
| Ampule | Amp |
| And | & |
| Ante Meridiem | AM |
| Anterior | Ant |
| Appointment | Appt |
| Approximate | Approx |
| Approximately | App |
| Arkansas | AR |
| Arkansas Children's Hospital | ACH |
| Arkansas State Hospital | ASH |
| Arkansas School for the Deaf | ASD |
| As Necessary | prn |
| At bedtime | h.s. |
| Attention | attn |
| Attention Hyperactivity Deficit Disorder | ADHD |
| Attorney ad Litem | AAL |
| Audible | Aud |
| Auditory Hallucinations | AH |
| Auditory and Visual Hallucinations | AVH |
| Axillary | Ax |
| Banana/Rice/Applesauce/Toast Diet | BRAT |
| Baptist Medical Center | BMC |
| Before meals | a.c. |
| Behavior | BX |
| Bilateral | Bil |
| Birth Control Pill | BCP |
| Blood Sugar | BS |
| Blood Pressure | BP |
| Blood Urea Nitrogen | BUN |
| Both Eyes | OU |
| Bowel Movement | BM |
| Bowel Sounds Audible | B.S.A. |
| Bridgeway Hospital | B'way |
| By Way | via |
| By | per |
| By mouth | P.O. |
| Calcium | Ca |
| Calorie | Cal |
| Cancelled | Cx |
| Capsule | Cap |
| Carbohydrates | Carbs |
| Cardiovascular | CV |
| Caucasian | C |
| Centers for Youth and Families | CYF |
| Centimeter | cm |
| Central Nervous System | CNS |
| Change | Δ |
| Check | Ck |
| Child & Adolescent Functional Assessment Scale | CAFAS |
| Child Behavior Checklist | CBCL |
| Children's Day Treatment | CDT |
| Children's Depression Inventory | CDI |
| Cholesterol | Chol |
| Chronic | chr |
| Chronological age | CA |
| Clear Liquids | CLQ |
| Closed Head Injury | CHI |
| Cognitive Behavioral Therapy | CBT |
| Collateral Service | CS |
| Complained of | C/O |
| Complete Blood Count | CBC |
| Compound | Comp |
| Continued | cont. |
| Court Appointed Special Advocate | CASA |
| Cubic Centimeter | ML |
| Culture & Sensitivity | C&S |
| Date of Birth | DOB |
| Day Treatment | Day Tx |
| Decrease | ↓ |
| Decreased or Diminished | decr. |
| Deep Tendon Reflex | DTR |
| Department of Children and Family Services | DCFS |
| Department of Human Services | DHS |
| Department | Dept |
| Diabetes Mellitus | DM |
| Diagnosis | Dx |
| Did not keep appointment | DNKA |
| Differential Leucocyte Count | Diff |
| Dilute | Dil |
| Disorder | D/O |
| Division of Youth Services | DYS |
| Doctor | Dr |
| Dressing | Dsg |
| Drop | gt. |
| Drops | gtt. |
| Drug Screen Test | DST |
| Ear/Nose/Throat | ENT |
| Education | Ed |
| Educational Therapist | ET |
| Electrocardiogram | EKG |
| Electroencephalogram | EEG |
| Elizabeth Mitchell Adolescent Center | EMAC |
| Elizabeth Mitchell Children's Center | EMCC |
| Elixir | Elix |

| | |
|---|---|
| Electronic Medical Record | EMR |
| Emergency Room | ER |
| Emotionally Disturbed | ED |
| Erythrocyte Sedimentation Rate | ESR |
| Et cetera | etc |
| Evaluation | Eval |
| Extract | Ext |
| Eye/Ear/Nose/Throat | EENT |
| Family Practice Clinic | FPC |
| Family History | FH |
| Family Therapy | FT |
| Fasting Blood Sugar | FBS |
| Feet/Foot | ft |
| Female | ♀ |
| Female | F |
| Fever of Unknown Origin | FUO |
| Flight of Ideas | FOI |
| Fluid | Fl |
| Follow-up | F/U |
| For example | e.g. |
| Fracture | fx. |
| Full Weight Bearing | FWB |
| Gastrointestinal | GI |
| Global Assessment of Functions | GAF |
| Glucose Tolerance Test | G.T.T. |
| Gonorrhea | GC |
| Gram | gm |
| Grandfather | GF |
| Grandmother | GM |
| Group Therapy | GT |
| Gynecology | Gyn |
| Habilitation Therapist | HT |
| Haemophilun B Polysaccharide | HbPV |
| Hallucinations/Delusions | H/D |
| Head/Eyes/Ears/Nose/Throat | HEENT |
| Headache | HA |
| Height | ht |
| Hematocrit | Hct |
| Hemoglobin | Hbg |
| Hepatitis B Surface Antigen | HBSAG |
| History | Hx |
| History & Physical | H&P |
| Homicidal Ideation | HI |
| Hospital | Hosp |
| Hydrochloride | HCL |
| Hydrogen Peroxide | $H_2O_2$ |
| Ideal Body Weight | IBW |
| Impression | imp |
| Incident & Accident | I&A |
| Incision & Drainage | I&D |
| Increase | ↑ |
| Increased/Increasing | incr |
| Individual | ind |
| Individual Behavior Protocol | IBP |
| Individual Therapy | IT |
| Information | Info |
| Injection | Inj |
| Input & Output | I&O |
| Insulin Dependent Diabetes Mellitus | IDDM |
| Intelligence Quotient | IQ |
| Intramuscular | IM |
| Iron | Fe |
| Kidneys/Urethra/Bladder | KUB |
| Kilogram | Kg |
| Laboratory | Lab |
| Large | Lg |
| Last Menstrual Period | LMP |
| Latral | Lat |
| Learning Disability | LD |
| Left Lower Quadrant | LLQ |
| Left | LT |
| Left Lower Lobe | LLL |
| Left Upper Lobe | LUL |
| Left Upper Quadrant | LUQ |
| Level of Care | LOC |
| Licensed Associate Counselor | LAC |
| Licensed Clinical Social Worker | LCSW |
| Licensed Master Social Worker | LMSW |
| Licensed Practical Nurse | LPN |
| Licensed Practical Technical Nurse | LPTN |
| Licensed Professional Counselor | LPC |
| Licensed Psychological Examiner | LPE |
| Licensed Psychological Examiner With Independent Practice | LPEI |
| Licensed Social Worker | LSW |
| Light & Accommodation | L&A |
| Liter | L |
| Lithium | Li |
| Little Rock Community Mental Health Center | LRCMHC |
| Little Rock School District | LRSD |
| Living and Well | L&W |
| Male | ♂ |
| Male | M |
| Master Treatment Plan | MTP |
| Maximum | Max |
| Measles/Mumps/Rubella | MMR |
| Medical Doctor | MD |
| Medication Management | MM |
| Medicine/Medication | Med(s) |
| Mental Age | MA |
| Mental Health | MH |
| Mental Health Diagnosis | MHD |
| Mental Health Evaluation | MHE |
| Mental Health Para Professional | MHPP |
| Mental Health Professional | MHP |
| Mental Retardation | MR |
| Mental Health Technician | MHT |
| Mental Status Exam | MSE |
| Midnight | M.N. |
| Milliliters | Ml |
| Milk of Magnesia | MOM |
| Minimum | Min |
| Moderate | Mod |
| Nasogastric | N/G |
| Nausea & Vomiting | N&V |
| Negative | neg |
| Neuromuscular | NM |
| Neurology | neuro |
| No Known Allergies | NKA |
| No known food allergies | NKFA |
| Non-applicable | N/A |

| | |
|---|---|
| None, Not Present | Ø |
| Non-weight bearing | NWB |
| Nonreactive | NR |
| Normal Sinus Rhythm | NSR |
| North Little Rock School District | NLRSD |
| Not Otherwise Specified | NOS |
| Objective | Obj |
| Obsessive Compulsive Disorder | OCD |
| Occupational Therapy | OT |
| Of each | aa |
| Ophthalmology | Ophth |
| Oppositional Defiant Disorder | ODD |
| Oral Polio Vaccine | OPV |
| Orientated times 3 | Ox3 |
| Organic Brain Syndrome | OBS |
| Oriented | O |
| Orthopedics | Ortho |
| Otitis Media | OM |
| Ounce | oz |
| Outpatient | OP |
| Ova & parasite | O&P |
| Oxygen | $O_2$ |
| Parent Child Relationship Problems | PCRP |
| Pathology | Path |
| Pediatric | Peds |
| Pelvic Inflammatory Disease | PID |
| Penicillin | PCN |
| Peptic Ulcer Disease | PUD |
| Performance Intelligence Quotient | PIQ |
| Phenylketonuria | PKU |
| Physical Hold | p.h. |
| Physical Therapy | PT |
| Physician Order | PO |
| Platelet | Pet |
| Positive | pos |
| Post Meridiem | PM |
| Post Traumatic Stress Disorder | PTSD |
| Posterior | Post |
| Pound | Lb |
| Pregnancy Urine Test | Preg UR |
| Prescription | Rx |
| Primary Care Physician | PCP |
| Protein | Pro |
| Pulaski County Special School District | PCSSD |
| Pulse | P |
| Pupils Equal Round Reactive to Light and Accommodation | PERRLA |
| Purified Protein Derivative | PPD |
| Quadrant | Quad |
| Quality Improvement | QI |
| Quart | qt |
| Range of Motion | ROM |
| Reactive Attachment Disorder | RAD |
| Rectal | R |
| Red Blood Count | RBC |
| Registered Nurse | RN |
| Registered Nurse Board Certified | RNBC |
| Regular | reg. |
| Regular Diet | Reg |
| Relapse Prevention Plan | RPP |
| Related to | R/T |
| Respiratory/Respiration | resp. |
| Respiratory Rate | RR |
| Return to Clinic | RTC |
| Right | rt. |
| Right Lower Quadrant | RLQ |
| Right Lower Lobe | RLL |
| Right Upper Lobe | RUL |
| Rule Out | R/O |
| Seclusion | sec. |
| Seriously Emotionally Disturbed | SED |
| Serum Glutamic Oxaloacetic Transaminse | SGDT |
| Side Effect | S.E. |
| Signs & Symptoms | S/S |
| Small | sm |
| Social | Soc. |
| Solution | Sol. |
| Specific Gravity | spgr |
| Specimen | Spec |
| Standard Score | SS |
| Straphylococcus | Straph |
| Streptococus | Strep |
| Suicidal Ideation | SI |
| Tablespoon | Tbsp |
| Teaspoon | tsp |
| Telephone Order | T.O. |
| Tempanic membrane | TM |
| Temperature | temp |
| That is | i.e. |
| Therapeutic Family Homes | TFH |
| Therapeutic Family Homes Program | TFHP |
| Therapeutic Foster Brother | TFB |
| Therapeutic Foster Father | TFF |
| Therapeutic Foster Parent | TFP |
| Therapeutic Foster Mother | TFM |
| Therapeutic Foster Sister | TFS |
| Therapeutic Leave | T.L. |
| Thorazine | CPZ |
| Thyroid Stimulating Hormone | TSH |
| Timeout | t.o. |
| Times | X |
| Transfer | trans |
| Trauma Focused Cognitive Behavioral Therapy | TF-CBT |
| Traumatic Brain Injury | TBI |
| Treatment | Tx |
| Treatment Plan | TP |
| Treatment Plan Review | TPR |
| Tuberculin | TB |
| Twice a Day | b.i.d. |
| Ultrasound | US |
| Ultraviolet | UV |
| Upper Gastrointestinal | UGI |
| Upper Respiratory Infection | URI |
| Urinalysis | UA |
| Urinary Tract Infection | UTI |
| Venereal Disease Research Laboratory | VDRL |
| Venereal Disease | VD |
| Verbal Intelligence Quotient | VIQ |
| Verbal Order | VO |
| Visual Hallucinations | VH |

| | |
|---|---|
| Vital Signs | v.s. |
| Vitamin | vit |
| Volume | vol |
| Warm & Dry | WD |
| Water | $H_2O$ |
| Week | wk |
| White | W |
| With (with a line drawn above the c) | c |
| Within Normal Limits | WNL |
| Without (with a line drawn above the s) | s |
| Year | yr |
| Years | Yrs |
| Years Old | y.o. |

## Appendix C
## Unapproved Abbreviations and Symbols
**(DO NOT USE – Applies to all orders and all medication-related documentation that is handwritten – including free-text computer entry-or on pre-printed forms)**

| Do Not Use | Potential Problem | Use Instead |
|---|---|---|
| Abbreviations for drug names | Misinterpreted due to similar abbreviations for multiple drugs | Write drug names in full |
| Q.D., QD, q.d., qd (daily)<br><br>Q.O.D., QOD, q.o.d., qod (every other day) | Mistaken for each other. Period after the Q mistaken for an "I" and the "O" mistaken for "I". | Write "daily" Write "every other day" |
| U (unit) | Mistaken for "0"zero, the number "4" four (4) or "cc" | Write "unit" |
| IU (International Unit) | Mistaken as IV (intravenous) or the number 10 (ten) | Write "International Unit" |
| Trailing Zero (X.0 mg)<br>Lack of leading zero (.X mg)<br>*(Note: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.* | Decimal point is missed | Write X mg<br>Write 0.X mg |
| MS<br>MS04<br>MgSO4 | Can mean morphine sulfate or magnesium sulfate<br>Confused for one another | Write "morphine sulfate"<br>Write "magnesium sulfate" |
| > (greater than)<br>< (less than) | Misinterpreted as the number "7" (seven) or the letter "L"<br>Confused one for another | Write "greater than"<br>Write "lesser than" |

**CENTERS FOR YOUTH AND FAMILIES**

| Policy/Number | Chapter 45 | Client Grievance Policy | |
|---|---|---|---|
| | | | |
| Effective Date | December 2016 | | |
| Expiration Date | December 2019 | | |
| | This policy is reviewed on a 3 year cycle. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Director of Risk Management | | |
| | Chief Operating Officer | | |
| | Chief Executive Officer | | |
| | Operations Committee, Chair | | |

**PURPOSE:** To provide clients and their families/guardians with a process to complain or grieve concerns regarding treatment.

**DEFINITIONS:**

**Complaint** – Any issue or concern a client, the client's parent, and/or legal custodian/guardian(s) may have regarding the services delivered at Centers For Youth & Families with which the client or parent/guardian is not pleased. Client complaints are resolved at a program level.

**Grievance** – A complaint that cannot be resolved at the program level to the satisfaction of the client, the client's parent(s), and or legal custodian/guardian(s) then becomes a client grievance and is handled at the administrative level.

**PROCEDURES:**

**I. Client Notification**

1. As part of the admission process, all clients and their legal guardians shall be informed of their right to express any concerns they may have regarding services at Centers For Youth & Families.
2. Written documentation will be included in the client record that the client and legal guardian have been advised of the grievance process.

**II. Client Complaint Review**

1. All issues/concerns identified by a client/guardian will be addressed by the manager of the program where the issues/concerns were identified.
2. All staff members shall be responsible for assisting clients and/or their legal guardian in expressing their concerns in writing.
3. Once a complaint has been received, it should be forwarded to the program manager, within 48 hours or the next business day (whichever occurs first).
4. The program manager shall respond to the client and/or legal guardian's complaint within 72 hours of receiving it.

**III. Client Grievance Review**

1. In the event that the concern cannot be resolved at the program level, the program manager will refer the client and/or legal guardian to the Director of Risk Management in order to file a formal grievance.
2. The Director of Risk Management will interview the party wishing to file the grievance in order to determine the nature and scope of the grievance.

3. The COO and Medical Director will be notified of the nature of the grievance.
4. The Director of Risk Management in conjunction with the program manager will determine who should conduct an administrative review of the grievance.
5. That individual has 72 hours to review and attempt to resolve the matter. If the matter cannot be resolved within 72 hours, the reviewer must notify the Clinical Operations Director and Medical Director of the estimated time needed to complete the investigation.
6. Once an administrative review has been conducted and recommendations made, the disposition of the grievance will be provided to the COO and Medical Director.
7. In the event that the grievance cannot be resolved by administrative review, it will then be forwarded to the CEO for resolution.
8. If the grievance cannot be resolved by the CEO within 3 business days, it shall be forwarded to Centers' attorney for recommendations, if necessary.

## IV. Agency Review

1. All client complaints are reviewed on a program level. Program Managers document the disposition of all client complaints. This information is available for review by agency administration and a summary version presented to the Performance Improvement Committee.
2. All client grievances are reviewed by the Director of Risk Management who seeks input from the CEO if needed. These grievances may then be forwarded to the Performance Improvement for additional review as necessary.

## V. External Review

1. A client and/or legal guardian have the right to express to external organizations, complaints regarding the quality of services received.
2. Centers' staff are responsible for directing a client's and/or legal guardian's complaint to external organizations, as appropriate.
3. Each program will identify for the legal guardian, in writing, those external organizations which accredit or license their program.
4. Notification, if made by the program, will be documented in the client record.

## VI. Documentation

1. All documentation regarding client complaints shall be maintained by the Program Manager. This information shall be maintained in a log that is available for external review, if necessary. A copy of all completed complaints are forwarded to the Risk Management Office.
2. All documentation regarding client grievances shall be forwarded to the Director of Risk Management for ensuring the integrity of the grievance process.
3. All documentation regarding client complaints or grievances shall contain the following information:

    - Identity of the client and/or legal guardian initiating the complaint or grievance
    - Specifics of the complaint or grievance
    - Efforts to resolve the complaint or grievance, and
    - Results of efforts taken to resolve the complaint or grievance

## VII. Notification

All client grievances regarding quality of service shall be forwarded to the Medical Director for review.

## VIII. Complaints Regarding Violations of HIPAA Regulations

All complaints of violations regarding disclosure of protected health information should be referred to the Centers' Privacy Officer at 666-8686 X 1550.

## Centers for Youth and Families

| Plan/Number | ORG-7 | Pharmacy Plan | |
|---|---|---|---|
| | | | |
| Effective Date | May 2018 | | |
| Expiration Date | May 2020 | | |
| | This plan is reviewed every 2 years. | | |
| Approval | TITLE | SIGNATURE | DATE |
| | Pharmacist<br>Health Care Pharmacy | | |
| | Pharmacist<br>City Drug | | |
| | Medical Director | | |
| | Operations Committee,<br>Chair | | |

This Organizational Plan has been reviewed and hereby approved per signature sheet.

**Pharmacy Plan**
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# Centers for Youth and Families
## Pharmaceutical Services Plan

HealthCare Pharmacy, Inc.
3401 Atwood Rd. Suite F
Little Rock, AR 72206
Ph (501) 888-7514
Fax (501) 888-7504 or (501) 888-1717

City Drug
201 East Gaines
Monticello, AR 71655
Ph (870) 367-530
Fax (870) 460-0257

### PURPOSE

The procedure for administration of pharmaceutical services shall be established to provide the best and most appropriate method of obtaining, dispensing, and administering medications. This procedure will also provide for the proper storage and disposal of all medications.
All Federal and State regulations shall be followed.

### ORGANIZATION

Healthcare Pharmacy and City Drug Pharmacy, hereafter referred to as "pharmacy", will provide services to all residential clients and to day treatment and outpatient clients who so desire. This will include 24 hours emergency service by currently licensed pharmacists and pharmacy technicians.

### DISPENSING

The pharmacy maintains the following schedule:

| | |
|---|---|
| Monday - Friday | 8:30 am to 5:00 pm |

For emergency service after hours, contact a pharmacist using the after hours contact list.

### REPORTING

The pharmacist is a member of the Medical Management Committee, and reports to the Medical Director.

**Letters in parenthesis refer to inserts included in back of the pharmacy policy.*

I. Pharmacy Procedures

A. Job Description

The pharmacist shall be responsible for the control of all medications delivered to the facility and for the proper provision of all pharmaceutical services.

Licensed Pharmacy Technicians shall be responsible for assisting the pharmacist in the performance of duties as approved by the Arkansas Board of Pharmacy.

1. Licenses

All pharmacists and pharmacy technicians will be appropriately licensed by the state of Arkansas.

2. Hours of Operation

The pharmacy is open Monday - Friday from 8:30 am to 5 pm. Orders needed for the same day should be placed no later than 1 pm.

3. After Hours-Emergency Contact

The after hours pharmacist contact list should be used for emergencies that arise outside of normal hours of operation.

B. Computer Service

The pharmacy will provide the facility with computer generated print-outs as requested. The following will be generated on a routine basis:

1. Admit Orders (C)

These 3 part printed forms will contain information needed to admit client to a particular program. Any desired quantity will be supplied upon request. Once completed, the second, yellow copy will be forwarded to the pharmacy. The top, white copy will be placed in the client's chart, and the back page will be placed in the MAR book for charting. The physician's signature on this form signifies acceptance of all of the orders as active orders. An order that is not clear will not be processed and clarification will be sought from the physician.

2. Physician's Orders/Medication Administration Records (D)

These 3 part printed forms will contain pertinent patient information such as name, age, weight, allergies, diagnosis, diet. They will be printed monthly so that they reflect the client's current list of medications and administration times. They will be sent a few days before the end of each month so that a nurse can check the accuracy of the form and sign. The physician's signature on this form renews all current orders (medications, diet, etc.) for another month. Any changes made by the physician on this form will serve as a new order and the pharmacy must be notified. The front page will be placed in the client's chart, the second page returned to the pharmacy, and the bottom page will be used as the MAR. At the end of each month, the MAR will be placed in the client's chart when the new one is received.

3. Correction Sheets

Before the end of each month, a copy of each client's physician's order page will be printed on plain white paper. These copies will be reviewed, corrected as needed, and returned by the nurse to the pharmacy as soon as possible. This will allow for the PO/MAR print out to be as correct as possible. The nurse responsible for reviewing the sheets will sign his/her name on the sheet.

4. PRN Floor Stock Meds

**Residential, Day Treatment & Destiny House** - The physician in each program may design a list of OTC items that the nurses may administer to the clients as needed. This list will be signed on admission as part of the client's admit orders. If a medication from this list is used, the nurse will write the medication on the MAR and chart it as given.
**Foster Care** - The physician will design a list of OTC items that he/she approves of the foster parents administering to the clients. Medications not listed, must be approved by the nurse/physician.

C. Billing

Each month a statement will be sent to the facility detailing any charges the facility incurred during the past month. Routinely, all medications that are billable to Medicaid by the pharmacy will be so billed. Any medications that are not covered by Medicaid or clients who do not have Medicaid, will be billed to the facility.

1. Pricing
All medications, forms, and books shall be priced by the pharmacy in the usual and customary manner for all clients.

2. Policy on Charging and Crediting Medications
If the facility assumes responsibility for a client who does not have a current Medicaid number, but does receive one, the pharmacy will retro bill Medicaid for appropriate charges and will credit the facility's account. It is the responsibility of the facility to supply the pharmacy with missing Medicaid numbers. Medicaid allows retro billing for up to 1 year from date of dispensing.

3. Policy on Returning Medications
**Residential & Destiny House** -nurses will return all full cards of non-controlled medications with delivery driver
- nurses will return any medications that have been punched, but can be repackaged or relabeled to be used by the same person
**Day Treatment** - only stock medications that have been billed to the facility but not opened can be returned

Medications that can NOT be returned from any program:
- any controlled medication
- cards that have medications already punched out
- any liquid, ointment, cream, or other medication in a multi-use container
- medications that have to be refrigerated

4. A statement will be sent to the facility each month showing a detailed list of each client's medication if it was billed to the facility. The stock account will also be listed.

**Residential, Day Treatment & Destiny House** - all medications will print on the statement, but only those charged to the facility will show a price (ones billed to Medicaid will show 0.00)

D. Inspections

Periodic inspections shall be done by the pharmacist to assure that all policies and procedures are being followed as set forth in this manual, that all medications are properly

and safely stored throughout the organization, and to insure compliance with the licensing and regulatory laws of the state. A report will be filled in a timely manner, and any discrepancies shall be immediately corrected by nursing staff.

1. Inspection Guide (H)
   The inspection shall include, but not be limited to the items on the guide and will be customized to meet the needs of each individual program.

2. Out of Date Medications
   Out of date medications will not be stocked by the facility. The Pharmacist will inspect for out of date medications at monthly-nursing station inspections. If out of date medications are found, these medications will be logged and discarded pursuant to the drug destruction policy. Staff should routinely check and pull any expired drugs and place them in a designated place to be destroyed appropriately by the pharmacist.

3. Drug Destruction
   a. The pharmacist will be responsible for the destruction of all medications that are discontinued or expired. A record (I) will be provided by the pharmacy to record all drugs to be destroyed in and will be kept in the med room. The nurse may record drugs in the book as they are placed in an appropriate location awaiting destruction.

   b. Controlled medications that have been discontinued will be documented on the appropriate Report of Drugs Surrendered form (J) and will be transported to the Arkansas Department of Health, Pharmacy Division by the pharmacist. These medications may be removed from the count by the nurse manager and kept under double lock until the pharmacist is notified and the appropriate form is completed.

4. Daily Refrigerator Temperature Log
   A log must be maintained that documents the temperature of the refrigerator at least on a daily basis (excluding times when the facility is closed.) The temperature must be maintained between 36 - 46 degrees.

E. Patient Profile Reviews
The Pharmacy will maintain a profile for each client that will include the client's name, age, weight, sex, diagnosis, medication allergies or sensitivities, current medication regimen, physician's name and phone number, and any other information the program determines necessary or useful.

1. Drug Interactions
   Each time a new prescription is added to the client's profile, the existing medications will be reviewed to determine that there are no drug-drug interactions with the new medication.

2. Drug-Food Interactions
   Each time a new prescription is added to the client's profile, it will be reviewed to determine that there are no major drug-food interactions.

3. Allergies
   Each time a new prescription is added to the client's profile, the medication will be compared to any allergies the client has to insure that the client is not allergic to the new medication.

4. Notification of Potential Problems
If one of the above situations occurs, pharmacy will notify the nurse with a description of the potential problem. The medication will not be filled without the prescribing physician's approval.

F. Safety Procedures

1. Medications are prepared and dispensed safely, according to laws and regulations and the standards of pharmacy practice

G. Record Keeping
Records are kept of the transactions of the pharmacy to maintain adequate control over the requisitioning and dispensing of all drugs and pharmaceutical supplies and the charging of clients for such. These records are retained by the pharmacy for a minimum of two years.

H. Infection Control Procedures

1. The pharmacy will follow all policy and procedures as outlined in the facility infection control policy.

I. Drug Recall Procedures

1. Upon receipt of a drug recall notice, the pharmacy will conduct a thorough search of existing stock to determine if the affected medication was purchased and take appropriate action per the recall letter.

2. The pharmacy maintains records of the company used to fill each prescription so that if a recall is issued to the patient level, the affected clients could be notified.

3. Members of the Medical Management Committee will be notified with the appropriate recommendation if a drug recall affects any medications that have been dispensed to the facility's clients.

J. Staff Development

1. The pharmacist shall be responsible for implementing the decisions of the Medical Management Committee concerning drug usage. The pharmacist is a member of this committee and will attend at least 75% of meetings.

2. The pharmacist will participate in the development and management of a facility formulary.

3. The pharmacist will act as a research person for the latest information on drugs and their usage.

4. The pharmacist will participate in teaching programs through orientation of personnel and inservice programs upon request.

5. The pharmacist will participate as required in the evaluation of the policies and procedures established in this manual.

6. The pharmacist will participate in patient care evaluation programs by providing physicians with drug evaluation forms and by assisting in evaluating these forms upon request.

7. The pharmacist will report to the Performance Improvement Committee on select topics upon request of the committee.

8. The pharmacist will attend and make contributions to any other committee as deemed necessary by the Medical Director.

K. The pharmacy will comply with all of the federal HIPAA regulations and has entered into a Business Associate with The Centers. The Centers has provided a copy of its privacy notice to the Pharmacy and Centers has been given a copy of the pharmacy's privacy notice.

II. Medication Acquisition

A. Authorization of Physicians to Prescribe/Order Medications
The medical director will provide the pharmacy with an updated list of physicians who are authorized legally and through the granting of clinical privileges to prescribe/order medications. The pharmacy will also be informed of any physician who is no longer licensed or has lost privileges. No medications, including common household remedies, shall be dispensed without orders from the physician. It is the program manager/service administrator's responsibility to notify the pharmacy if the physicians change programs so that the P0/MAR and prescriptions will reflect the correct physician's name.

B. Formulary
The purpose of the Centers for Youth and Families drug formulary is to ensure that medications prescribed by Centers' physicians are approved by the Medical Staff to ensure client safety and quality of treatment. Centers formulary includes all medications covered by Arkansas Medicaid, all Centers approved for stock and emergency medications, and other medications approved by the Medical Director and contained in the Centers for Youth and Families formulary.

**Review Process:**

1. The drug formulary shall be reviewed as required by Medical Management Committee.
2. Updates shall be based on medical need, need for addition of new medications approved by FDA and as deemed appropriate by the Medical Staff.

1. Adding Drugs to the Formulary

a. All requests will be made to the Medical Director via the "Request for Formulary Additions Form" (K). The Medical Director will present the request to the physicians either at the next Medical Staff meeting or a STAT meeting. Criteria to consider in determining whether a medication should be added to the formulary include:
   i. Whether the medication is appropriate for the treatment of the condition identified by the requesting psychiatrist;
   ii. A review of all information available regarding the medication, particularly if it is relatively new (must be submitted by the requesting physician) including PDR, Epostraphe or Drug Insert information;
   iii. Efficacy and side effects profile of the medication;
   iv. Cost benefit.

   If the Medical Staff approves the addition, the form will be signed by the Medical Director indicating approval and the medication will be added to

the formulary.

If a physician requests urgent consideration, the Medical Director may choose to approve the addition temporarily until a meeting can be held.

Pharmacy will be notified by the Medical Director of the decision of the Medical Staff.

2. Pharmacy Process

   a. Pharmacy will be responsible for monitoring all prescriptions/orders for medications by CYF physicians for formulary compliance.
   b. If a physician writes an order for a medication which is not in the formulary, pharmacy will not issue the medication and will inform the physician and the Medical Director. Pharmacy/Medical Director will inform the physician regarding the process.
   c. A new client admitted on a non-formulary medication may continue on that medication at the physician's discretion.

3. Physician Process

   a. Physicians will be responsible for ensuring that all medications prescribed by the physician are in the CYF formulary.

C. Client's with Active Medicaid or Private Insurance

**Residential & Destiny House** - The pharmacy will fill all prescriptions for residential clients, except for those from the emergency room, which may be filled at the hospital if possible. Any prescription that is billable to Medicaid or private insurance, will be so billed if the client has an active number. Alternate local pharmacy may be used in an emergency.
**Day Treatment** – Clients with active Medicaid benefits or private insurance may have prescriptions dispensed from the pharmacy. The nurse or physician will order the needed medication from the pharmacy. A sufficient quantity will be packaged to meet the client's needs at school and a separate bottle will be sent for home use.

D. Clients without Medicaid or Private Insurance

**Residential & Destiny House** - The facility will be responsible for all charges.
**Day Treatment** - Clients may have prescriptions dispensed from a pharmacy of their choice provided that they meet the facility's labeling requirements.

E. Order and Receiving Form (M)
The pharmacy will provide the facility with an Order and Receiving Form. The nurse ordering the medicine will complete the appropriate lines of the form, then place the order. Forms will be filed in the appropriate book and kept in order by date.

1. Telephone Orders
   Nurses may call in orders during normal hours of operation. Orders will be written and then read back for verification.

2. Faxed Orders
   Nurses may fax the Order and Received form to the pharmacy 24 hours a day. If faxed during working hours, the nurse will call the pharmacy to verify receipt of the fax. (This is especially important if something on the fax is needed for delivery that day.) Routinely, faxes received 1 hour prior to closing or later, will be

filled the next day, unless we are notified that they are needed that night. Any faxes sent after 4 on Friday or on Saturday that need to be delivered on Saturday, require a phone call to the pharmacy during business hours to arrange a Saturday delivery.

3. Upon receipt of the medications, the nurse receiving shall document on the appropriate line of the Order and Receiving Form that the medications were received.

F. Physician Use Box (N)

**Residential & Destiny House**- the physician and Medical Director will determine the medications needed in an emergency. These medications will be kept in a locked box. Upon an order by the physician, the nurse will break the seal and use medications from the box. The appropriate log will be completed documenting what patient used what med and the nurse's initials. A list of the contents is on the outside of the box. The pharmacy will be notified as soon as possible after the box is opened. The contents of the box are the possession of the physician. At each shift change, the box will be checked to assure that it is locked. If the lock is missing, the pharmacy will be notified and the contents counted by the nurses until a new box is sent. The expiration dates will be checked during inspections by the pharmacists.
**Day Treatment** - the facility will not have access to emergency prescription medications except by notification of the pharmacy and delivery of such meds.

G. Floor Stock (O)

**Residential, Day Treatment & Destiny House-** the physician will determine the OTC medications that shall be floor stock. A list of these medications will be posted in the med room at each program.

Floor stock medication vials shall be marked with the date opened and the appropriate expiration date.

H. Standing Orders for Floor Stock Medications (P)
Physicians may establish protocols for the treatment of general complaints such as fever, sore throat, itching, etc. For each medication desired, a dosage and frequency must be established. These protocol orders will be signed by the physician at the time of admission and are automatically renewed each month when the physician signs the physician's orders and must be documented on the MAR if administered. It is the responsibility of duty nurse to record follow up measurements of pain/symptom relief at predetermined intervals after prn medication administration.

I. Ordering Schedule II Medications
A written prescription for Schedule II medications is required. The prescription must be faxed to the pharmacy to order the medications. The original prescription will be picked up during the medication delivery.

J. Labeling of Medications
All medications will be labeled in accordance with federal and state regulations governing such medications. Labeling will include client's name, physician's name, name and strength of medication, complete directions for use, expiration date, initials of dispensing pharmacist, date of issue, address and telephone number of pharmacy, Caution: Federal Law statement, manufacturer, and other notations necessary for proper storage and handling of the medication. The directions for use will be written in normal lay terms using either standard times such as 8 AM or using military time such as 0800 as determined by the programs. Cautionary labels will be included when necessary.

K. Medications Brought into Facility by Clients

1. Medications brought into the facility by the client/responsible party, may be administered to the client (if the medication is labeled appropriately) until such time as the attending physician reviews the client's medications and approves the orders or makes changes.

2. Consent must be obtained from the client's parent/guardian before administering the medications.

3. If there is a suspicion that the medication is not the name on the label, the Poison and Drug Information Center (1-800-3-POISON) will be contacted to identify the medication. If still unidentified, the dispensing pharmacy will be contacted. Medications that cannot be identified or appear adulterated will NOT be administered and the physician will be contacted immediately.

4. If the medication is not labeled appropriately, it should be returned with the client's family or placed in the box of medications to be destroyed and an agency incident report should be completed. Inappropriately labeled medications may NOT be administered to the client.

   a. Labeling Requirements for Medications
   Original container issued by pharmacy
   Client's name
   Correct directions for administration
   In date (not expired)
   Physician's name

L. Quantity Dispensed
All medication orders shall be filled for a month's supply unless otherwise requested.

M. Generic Substitution
Unless specified by the physician, all medications will be dispensed in the generic form if available. If the physician does not want the generic dispensed and the medication is being paid for by Medicaid, then the physician must follow the requirements by Medicaid to obtain a brand name drug.

N. Packaging of Medication

1. Medications for use at home will be dispensed in the original container or in amber vials or ovals with child resistant caps, the appropriate labeling and an expiration date of 6 months or less where appropriate.

2. Medications for use at the facility will be packaged in blister packs or bubble packs and the appropriate labeling and an expiration date of 6 months or less where appropriate.

O. Patient Package Inserts
Patient package inserts will be sent for estrogen and estrogen containing medications when these medications are dispensed. It is the physician's discretion if this insert is given to the client or not. Medication information guides that are required by law to be dispensed with medications are available at the facility.

P. Sample Medications
Sample medications will not be dispensed from the pharmacy. Samples will not be used by the clients except as per the facility's policy, i.e., coupons from drug companies may

be redeemed for sample medications only by prescription of the physician.

Q. Automatic Stop Order Policy

1. All medication orders which do not specifically indicate the number of doses to be administered will be automatically stopped in 30 days.

2. Medication orders will not be renewed without a physician's order. This may be accomplished by the physician signing the monthly physician's orders sheet, by telephone verification of the order, or by handling the order as a new medication order.

R. Repackaging / Relabeling of Medications

1. If a medication order is changed and the medication can continue to be used by the client (ex. taking 2 tablets will equal new dose) then the pharmacy will relabel the medication to reflect time changes, etc. This will be done only for medications dispensed by this pharmacy.

2. It is the nurse's responsibility to ask for relabeling of medications.

3. The nurse will not alter the label of the existing medication in any way other than to make an " X " through the label and write " See MAR for directions." The nurse will NOT write the new directions on the label.

S. Admixture of Parenteral Products

Admixture of parenteral products will not be performed in the facility or be utilized by the clients.

T. Investigational Drugs

Investigational drugs will not be utilized.

U. Compounded Prescriptions

Any compounding of medications will be done by the pharmacist.

V. Refills

Prescription orders will not be refilled without a physician's order.

1. To order a refill for a medication, follow the procedure for ordering a new medication. Check the appropriate box on the Order and Receiving Form page to reflect that the order is for a refill and not a new order.

W. Yellow Pharmacy Copy of Physician's Orders

The yellow copy of all orders should be placed in the pharmacy pick-up box and given to the delivery person on a regular basis or mailed. The pharmacist will verify the orders that are phoned or faxed with this copy to assure the accuracy of the order usually within 24 hours, but not more than 72 hours following receipt of the yellow copy.

X. Pharmacy Verification of Correctness of Orders Filled for Delivery

All medications will be checked by the pharmacist before they leave the pharmacy regardless of whether the medication was filled by a pharmacist or technician. A check will be placed on the delivery sheet beside the medication's name to attest to this.

Y. Leave of Absence Medications

**Residential & Destiny House** - Medications will be sent from the facility for clients who will be leaving on pass.

1. A physician's order has to be written stating that the client has permission for a

therapeutic leave of absence with medications.

2. The LOA form will be completed with the client's name, date and time of departure and return.

   Foster Care- For a client who will not be under the care of the foster family for a period of time, the medications that the foster family has will be sent with the client to be administered during the leave of absence. The medications will be returned with the client.

Z. Discharge Medications
Any medication may be sent if the physician writes an order and it is labeled and bottled appropriately. Controlled medications must be signed out of the Controlled Substances Book by the parent/guardian. (Bubble packs may not be sent unless the parent/guardian signs a note stating that they understand they are receiving medications that are not in childproof packaging and will take the appropriate precautions.)

AA. Wasting of Medications

1. Non-controlled Medications
   To waste a non-controlled medication due to breakage, client refusing dose, spitting out, etc., the dose will be placed in an envelope or package, labeled with the client's name, drug name, date, nurse's signature, and why it is being placed in the box of medications to be destroyed. If documentation is required on MAR, such as a circle for refusing dose, this will also be completed.

2. Controlled Medications
   To waste a controlled medication due to breakage, client refusing dose, spitting out, etc., the dose will be placed in an envelope or package, labeled with the client's name, drug name, date, nurse's signature, and why medication is to be destroyed. It will continue to be counted unless the nurse manager signs it out and assumes responsibility for it until pharmacy picks it up and takes to the Health Department for destruction. Appropriate documentation on the MAR must be completed.

BB. Shortage and/or Outage of Medications

1. In the event that a medication is unavailable, the pharmacy will notify the nursing staff. The nursing staff will notify the appropriate physician. The physician may then choose to put the medication on hold or substitute a similar medication. The pharmacy will make an effort to obtain all medications ordered. Only those medications unavailable from the manufacturer should pose a problem. Staff will be informed of the proper steps to take in the event that a medication is unavailable.

2. In the event of a disaster, the pharmacy will make every effort to obtain medications for the facility by whatever means is available. If this pharmacy is unable to obtain or dispense medications, then prescriptions may be transferred to another pharmacy until the emergency is resolved.

III. Medication Delivery

A. Courier Service
A driver will be provided by the pharmacy for delivery and pick-up at the local facility.

1. The delivery person will go to the designated location for drop-off of medications and will obtain the signature of an approved person before delivering the medications.

B. Mail Service
Medication orders for the DTS clients that are sent to their home will be packaged appropriately and delivered via USPS with delivery confirmation.

C. Emergency Delivery
If an emergency delivery is needed, contact the pharmacist to make the appropriate arrangements. The pharmacy will make an effort to see that true emergency deliveries are made as soon as possible

D. A delivery sheet (Q) listing the client's name, medication, and quantity delivered will be sent with each delivery. The person accepting responsibility for medications will verify the contents of the delivery and sign the sheet with their full name, the date and time received, and return the sheet to the pharmacy with the delivery person. The second copy of the sheet may be kept by the facility for its own use.

IV. Medication Storage

A. Storage upon Receipt of Medications
Medications will be placed in the designated place after delivery. This should be a locked area with limited access. Once the nurse receives the medications, they will be logged in the Order and Receiving Form as received and placed with the client's other meds.

B. External drugs, internal drugs, poisons, and perishables will be stored in separate areas or on separate shelves.

C. Medication that must be refrigerated to ensure stability will be placed in a refrigerator specifically designated for storing drugs. The refrigerator will be located in a locked area and temperature will be maintained between 36-46 degrees. External medications will be kept separate from internal medications. Only medications can be stored in this refrigerator or medications must be kept in a separate locked box in the refrigerator. TB and Insulin will be kept in separately labeled areas.

D. No out-of-date medications will be stocked. They will be placed in the appropriate place awaiting destruction.

E. Foster parents will be instructed in the correct procedures for proper storage of medication in the home.

F. Storage of Prescription Medications in facility

Medications will be stored in the medication cart or cabinet. Internal and external medications will be separated.

1. Multi-dose vials of injectable medications will be labeled with the date opened and appropriate expiration date.

2. Non-controlled Medications
Non-controlled Medications will be stored in a locked, properly lighted, ventilated, and sanitary area with access limited to the approved staff.

3. Controlled Medications
Controlled Medications will be stored in a double-locked, properly lighted, ventilated, and sanitary area with access limited to the approved staff.

4. The area (cabinet or medication room) where the medications are stored will be

locked when not attended by authorized personnel and the door can be opened from the outside only with a key. The keys for the room shall be in the possession at all times of the person assigned to medications.

G. Storage of Medications to be Destroyed

1. Medications that are awaiting destruction will be kept in a designated place marked "Drugs to be Destroyed".

2. Controlled medications will be kept locked and marked discontinued on the card until such time the pharmacist completes the Report of Drugs Surrendered form so the medications can be taken to the Arkansas Dept. of Health for destruction.

H. Clients Possession of OTC Medications

1. No medication shall be retained by the client with the exception of non-legend items that do not contain the statement "Keep out of reach of children," unless specifically ordered by the attending physician.

V. Medication Administration

Medications shall be administered only upon the order of a legally authorized individual, a licensed physician or licensed dentist, who is approved by the medical staff. Medications shall be administered only to the client to whom prescribed.

**Residential, Day Treatment & Destiny House** - medications will only be administered by a registered nurse or licensed practical nurse in accordance with any laws and regulations governing such acts.

A. Proper Documentation of Routine Medications

Medications shall be administered to clients according to current Policy and Procedures.

1. The signature of the person administering the medication shall be recorded once on the back of each MAR to verify the initials.

2. Upon administering a medication to the client or facilitating self-medication, the person shall initial the MAR in the appropriate box.

3. If a medication dose is not administered, the box must be circled and documentation must be recorded on the back of the MAR indicating why dose was not given.

If a client is on LOA, the letters "TL" for therapeutic leave may be charted without circling or documenting on the back of the MAR. "TL = therapeutic leave" must be documented one time on the back of the MAR where the nurses' initials and signatures are recorded.

If any other mark is used to symbolize that a client was not given a medication (e.g. When a day treatment client is at residential), the mark used must be recorded on the back of the MAR in the nurses' initial and signature section with an explanation.

4. Completed medication administration records will be filed in the client's chart. Foster parents will return the MAR each month and subsequently receive the new one.

5. Unsupervised self-administration of medications by clients is strictly prohibited regardless of age.

B. Proper Documentation of OTC PRN Medications
Foster parents and/or nurses may determine if a client needs an OTC PRN.

1. If an OTC PRN is administered, the initials of the person administering will be documented in the box on the front of the MAR. The back of the MAR will be completed with the time given, medication given, and reason for administering. The effectiveness of the PRN must also be documented on the back of the MAR.

C. Proper Documentation of Controlled Medications

**Residential, Day Treatment & Destiny House**- a narcotic book will be accurately maintained by each program.

1. Receipt of a controlled medication will be documented appropriately in the book.
2. As a dose of a controlled medication is given, it will be appropriately documented.
3. When a controlled medication is discontinued and sent for destruction, the book will be documented appropriately.
4. The controlled medications will be counted by the oncoming and outgoing person with every shift change and will be signed in the appropriate place to verify accuracy of the count. If any discrepancies are discovered, the program manager, nurse manager, physician and pharmacist must be notified immediately.
5. In a program that does not have regular 24 hours shift changes, the narcotics must be counted at least weekly by the nurse and another person and the narcotic book documented appropriately. Any discrepancies must be reported immediately to the program manager, nurse manager and physician.
6. If it is determined that controlled medications are unaccounted for, the facility's policy for documenting such should be followed. The pharmacy must be notified of the problem and forwarded a copy of the incident report. Unresolved shortages or a pattern will be reported to the Pharmacy Division, Arkansas Dept. of Health and the Board of Pharmacy and other agencies as appropriate.

D. Medication Administration Times
Labels will be printed using requested time schedules. If a different time is desired, it must be ordered for that specific time.

E. Proper Documentation of New Orders Added During Month
If a new order is placed after the MAR has been printed for the month, the nurse/foster parent may write the order in a blank MAR box, sign and date it, and begin charting the doses given according to facility policy. If the MAR page is full, then a new, blank MAR page may be started.

F. Adverse Drug Reactions / Medication Errors

a. Definition of an Adverse Drug Reaction:

**Adverse Drug Reaction:** A response to a medicinal product that is noxious and unintended and that occurs at doses normally used in humans for the prophylaxis, diagnosis, or treatment of disease or for the restoration, correction, or modification of physiological or psychological function.

**Significant Adverse Drug Reaction:** An adverse medication reaction experienced by an individual that requires intervention to preclude or mitigate harm or that requires monitoring to confirm that it resulted in no harm to the individual.

**Adverse drug reactions include but are not limited to**:

- hypersensitivity reactions (fever, rash, asthma, serum sickness, etc.)
- drug interactions
- drug response that necessitates or results in
  - complication of diagnosis
  - supportive treatment
  - prolonged stay in facility

- stopping the drug
- changing the drug
- death

b. **Definition of a Medication Error:** A medication error occurs when there is a discrepancy between what a physician orders and what is reported to occur, regardless of how the client obtained the medication.

If a client is suspected of having an adverse drug reaction or a medication error has occurred, the appropriate form should be completed and facility policy followed.

1. Medication orders may be cancelled or temporarily suspended if a suspected adverse drug reaction or medication error has occurred to warrant holding the medication. The physician or physician-on-call must be immediately notified and further orders obtained by the nurse.
2. The MAR will be documented by circling the box if a medication is withheld and the reason will be documented on the back.
3. A copy of the report will be forwarded to the pharmacy and a copy will be placed in the client's chart.
4. Foster parents will be instructed during medication teaching to report all medication errors & adverse drug reactions to the respective out-patient nurse.
5 If the Medical Director deems significant, adverse reactions will be reported to the FDA.
6. Medication errors made by the pharmacy will be addressed using the Centers medication error form and will be completed by the Nurse Manager and Pharmacist.

VI. Miscellaneous

A. Transferring Medications between the Center's Programs
The physician may write an order for a client's medications to be sent with him if he is transferred to a different program. The new program will request repackaging by the pharmacy, if needed.

B. Reference Material
A current reference book or internet access shall be maintained by the facility in order to furnish staff with adequate information concerning medications.

Other references that the physicians, nurses, or pharmacists deem appropriate will also be available.

C. Acceptable Abbreviations and Chemical Symbols
Orders involving abbreviations and chemical symbols will be carried out only if the abbreviations and symbols appear on a standard list approved by the medical staff as found in Chapter 44, Client Records Policy. Additionally, there is a list of unapproved abbreviations and symbols also found in Chapter 44, Client Records Policy.

D. Accidental Poisoning
Appropriate facility protocol will be followed for any suspected poisoning. The physician will be notified, the local poison control center contacted, and instructions followed. The phone number for the local poison control center will be posted in a visible place at nursing stations and by all foster families.

1-800 - 3 - P O I S O N (1-800-376-4766)

E. Terminology/Unclear Orders
Any order that uses unclear terminology, is illegible, or appears inappropriate will be

verified by the pharmacy before the order is filled.

F. Meteorology and dosage conversion tables (R)
The pharmacy will assist the nursing staff with converting any dosage needed by a client. The dosage will be written on the label to clearly identify the amount to be used or given to the client.

G. Drug Product Problem Reporting
Any time a problem is found in the consistency of a medication (e.g. tablets crumble, medication is discolored, injectables solidify), the pharmacy will be notified. The appropriate form will be completed and sent to the FDA by the pharmacy. The physician will be notified.

I. Missed Birth Control Pill Policy
If a client misses a scheduled dose of a birth control pill, that pill will be administered as soon as possible. Then the next routine dose will be given as scheduled.

If it is 24 hours after the missed dose (i.e., next dosing time), the pharmacy or physician will be contacted to determine the proper method for resuming the medication.

If the missed dose is due to lack of compliance (client refusal), then the prescribing physician will be notified before a new pack is started.

VII. Drug Samples

A. Prescription drug samples shall not be available or utilized within the Centers for Youth and Families by physicians or nursing staff except under the following circumstances:
1. Physicians who want to start a client on starter medications via drug assistance programs from pharmaceutical companies may do so strictly with a prescription, and only if the company will forward the medication to our pharmacy for labeling, or the client receives a certificate from the pharmaceutical company for obtaining the medication from a pharmacy of their choice.

2. Medication dispensed under these types of programs are dispensed as legal prescriptions to the client and meet all the requirements prescribed by law.

B. No medication samples will be given directly to the client by physicians, nurses, or any Centers for Youth and Families staff.

C. No medication samples will be stocked by physicians, nurses or any Centers for Youth and Families staff.

Artificial Tears
B12
Baby Oil
Benzoyl Peroxide
Betadine
Blood Glucose Test Strips
Calcium
Calcium with D
Debrox Ear Drops
Flu Vaccine
Lotion
Melatonin
Mineral Oil
Mouthwash
Multivitamin
Multivitamin with Minerals
Niacin
Selsun Blue
Swimmer's Ear Drops
TB Skin Test
Thum
Vaseline
Wart Remover
Witch Hazel

# Attachment E

# Little Rock Community Mental Health Center Organization Chart

See Attachment C: Organizational Chart