



Department
of Health

Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office of Children
and Family Services

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner of Health, DOH

ANN MARIE T. SULLIVAN, M.D.
Commissioner, OMH

ARLENE GONZÁLEZ-SÁNCHEZ, M.S., L.M.S.W.
Commissioner, OASAS

SHEILA J. POOLE
Acting Commissioner, OCFS

Medicaid State Plan Children and Family Treatment and Support Services (CFTSS)

Provider Guidance: *Health Record Documentation*

June 2022

This document is intended to provide implementation guidance with respect to the [Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children's Behavioral Health Early and Periodic Screening and Diagnostic Treatment \(EPSDT\) Services](#). This guidance document addresses only selected portions of the Manual and does not include the full Manual text as such, it should not be relied upon as a substitute for Manual.



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I. Purpose

This document is intended to provide implementation guidance on the principles and documentation requirements for the provision of Children and Family Treatment and Support Services (CFTSS), with specific regard to treatment planning and progress notation.

For the purpose of this guidance document, “child” refers to a child or youth between the ages of birth to 21. “Documentation” refers to all necessary elements of a child’s health record; inclusive of the requirements and practices necessary to facilitate the admission to CFTSS, the provision of care, and discharge.

Why is documentation important?

Health records are a fundamental and integral part of ongoing care, and an adjunct to good clinical care. The documentation comprised within the health record explicitly and accurately reflects the nature, scope, and detail of the health care provided.

Documentation serves as a means of accountability to the individuals receiving services, as well as, to county, state and federal authorities. It demonstrates the provider’s compliance with regulatory requirements, and the quality and efficiency of the care provided.

Complete and accurate documentation in a health record fosters continuity of care and communication between the providers and the child and family. When considering the significance of health records, the responsibility of the provider to the child and family receiving services cannot be overstated. The provider agency is responsible for the actual health record, while the child and family¹ direct and authorize its content.

Participation from the child and family in the development and management of the treatment plan assures the documentation reflects the wants and needs of the child and family. The child and family have a right to know and access the content of their record, and determine when, how and with whom the content is shared.

¹ The term “child and family” refers broadly to those individuals who have responsibility for directing the medical care of the child, consenting for services and the approval of treatment plans.



Documentation serves as a means of demonstrating service quality and efficiency and is expected to reflect consistency in the need, focus and direction of the service. The clinical connection between the behavioral health assessment, medical necessity for a service, treatment plan, progress notes, and subsequent plan reviews, should be clearly evident. All documentation should support the type, frequency, scope and duration of the service and interventions provided, including the clinical rationale for modifications made during the course of service, such as changes in needs, goals, interventions, scope, frequency and duration.

Tip: *Qualitative documentation assists providers in communicating with managed care plans to demonstrate medical necessity for any given service on behalf of a child and family. It will support and justify a child's appropriateness for CFTSS, the continuing care needs or the appropriateness for discharge.*

II. Assessment

All services require an initial assessment to inform the treatment planning process. Given each service within the CFTSS array has unique scope, the type of assessment used may vary depending on the service type. While referral information and previous assessments may be helpful to understand former or current service or treatment involvement and response, an initial service assessment can provide useful information and insight into current challenges impacting a child's ability to cope and function in aspects of their life.

Despite the occurrence of previous assessments, it is critical that an assessment occur to specifically inform planning for the services delivered via CFTSS. Assessments are designed to gather and assess relevant information that can be used to clarify priority needs and assist with treatment planning. The assessment process typically involves meeting with child/youth, parent/caregivers and other significant family members and/or collaterals that provide support to the child/youth and maintain a significant role in the child's life. Assessments may involve interviews and observations within the child's natural environment and while engaging in social interactions to understand the child within the context of their environment and relationships. Similarly, Family Peer Support Services (FPSS) may observe the parent/caregiver as they interact with the child to better understand the relationship and functioning.



Additionally, a review of relevant records or coordination with people (practitioners, school personnel, etc.) that can provide additional information may help to formulate a comprehensive understanding of the family's needs and history. After reviewing and analyzing all information, the treatment plan is developed via a collaborative planning process with the child and family/caregiver to outline goals and action steps.

As service delivery progresses, the assessment process will continue throughout the service episode. Continually monitoring a child and family's response to intervention will help to inform the ongoing treatment planning process and assist the family and service provider with understanding when changes are needed and/or when additional support or service intervention are warranted.

All assessments, whether comprehensive or periodic, must be documented, identify the methods and/or evaluation tools utilized (if applicable), provide justification for the treatment plan and its subsequent adjustments, and be included with the child/youth's Health Record. Assessments conducted must be done within service scope and in alignment with staff competencies

Readmission

There may be circumstances in which a child was discharged from CFTSS but readmission may be necessary. Although the provider may be familiar with the child and family, an initial assessment must still be completed. Given needs and circumstances are ever evolving, an assessment helps a provider understand any changes that may have occurred that led to a decline in the child's condition and functioning thus warranting readmission. Further, the assessment informs the strategies or interventions needed to support the child and family and subsequently guide the treatment plan.

When a child was previously enrolled in CFTSS especially when the enrollment occurred recently, a comprehensive assessment may not be necessary. Rather, a re-assessment may sufficiently identify changes in the child and family's needs and priorities, circumstances, level of risk, or other pertinent information that may have changed since last enrolled. Whether a comprehensive assessment or brief re-assessment is conducted, demonstration that an assessment occurred must be recorded in the child's case record.

NOTE: An LPHA Recommendation demonstrating medical necessity is still required for readmissions.



Other Licensed Practitioner (OLP)

A ‘Licensed Evaluation’ under the scope of practice for a Non-Physician Licensed Behavioral Health Practitioner (NP-LBHPs) or Other Licensed Practitioner (OLP) allows for the completion of a comprehensive assessment for the purpose of determining the conditions and/or symptoms needing to be ameliorated, functional limitations, diagnostic impressions and service needs to inform treatment planning. OLPs may also conduct assessments during the course of service to obtain subsequent clinical information about the child/ youth’s and family/caregiver’s response to the service provided in order to further its effectiveness, determine the continuing needs and identify additional or alternative services or interventions needed to attain goals. Thus, in the context of CFTSS, ‘Licensed Evaluation’ (or assessment) refers to two different processes – the initial comprehensive assessment which may include a diagnostic assessment; and a periodic assessment of progress and current functioning for the purpose of determining continuing needs to inform treatment planning.

In some instances, the initial comprehensive assessment of a child may yield a recommendation for ongoing psychotherapy to be provided through OLP; in other instances, however, the Licensed Evaluation may be the only OLP service component needed. Although treatment plan reviews necessitate an assessment of the child/youth’s progress, this would *not* require the completion of a comprehensive assessment thus should be conducted with more frequency but shorter duration. In instances where a child is engaged in ongoing psychotherapy with the OLP, the periodic assessment of progress and functioning needed to inform treatment planning, may be conducted through the routine counseling session/process depending on the level of complexity of need.

III. Treatment Plan

For the provision of CFTSS, a treatment plan is required for every child. A treatment plan is a dynamic document that is current, reflects the unique strengths and needs of the child and family, establishes the child and family’s goals and identifies the services and interventions needed to assist in accomplishing these goals. It also includes a means for determining when goals have been met, and the criteria for the appropriate discharge and/or transition to other needed services, all reflective of medical necessity.



Why is treatment planning important?

Treatment planning is as significant to the care of a child and family as the interventions provided. It is a therapeutic process that engages the child and family in defining their desired goals and the action steps by which to achieve them.

The treatment plan is a core element of service documentation. It is a plan for what, when and how services will be delivered, and is developed collaboratively by the provider(s), child and family. The treatment plan is the agreement between the provider, child and family as to what changes need to occur, what services and participants will help achieve those changes and how progress toward those changes will be measured.

A treatment plan supports the child and family in remaining focused on their goals and progress made toward achieving them, and also serves the entire provider team in doing so. A treatment plan is a tool to promote effective communication between collaborative providers to deliver integrated, well-coordinated care.

Guiding Principles of Treatment Planning

A treatment plan should serve as a roadmap for recovery, developed in partnership with the provider, the child/youth, family/caregiver, and significant others involved in the child's treatment. Providers should be guided by the following principles when engaging children and their families/caregivers in the treatment planning process.

Individualized, Child Centered and Family Focused

Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. An individualized, child centered treatment planning process addresses the unique needs, preferences, desires and strengths of the child and family/caregiver. While treatment planning is centered around the developmentally appropriate needs of the child, it takes into consideration the family/caregiver's integral role in the care and recovery of the child. It emphasizes shared decision-making approaches to empower the family/caregiver, provide choice, minimize stigma and establish family driven goals. The family participates as full partner to the extent possible and appropriate, in all stages of planning and decision-making including treatment implementation, monitoring and evaluation.



Strength-based

Strengths-based practice relies upon a collaborative process between the provider, child and family, enabling them to work together to determine a treatment plan that draws on their strengths and assets. In doing so, the quality of the relationship between the provider, child and family is strengthened to enhance the quality and efficacy of care. Working in a collaborative way promotes the opportunity for children and families to be active participants rather than solely consumers of services.

The strengths identified through the assessment process are incorporated into the treatment planning process and the treatment plan. This includes the identification of family members and significant others (collaterals) who provide support and have a meaningful role in the child's ongoing care or development. This may also include interventions and activities which build upon the child or family's competencies, interests, beliefs, values and practices that serve as a source of support or growth.

Culturally and Linguistically Responsive

Awareness and responsiveness to cultural differences and diversity is integral to effective care. Services are delivered in a manner that recognizes and respects the culture and practices of the child and family, including the awareness and understanding of different cultural groups' experiences. Such experiences include but are not limited to: oppression and social diversity with respect to race, ethnicity, sex, sexual orientation, gender identity or expression, disability, religion, immigration status and its impact on engagement and perception of care. Treatment plans identify how cultural, linguistic or other aspects of diversity will be addressed if they may affect the child/family's engagement and participation in care. If an accommodation is needed to ensure culturally and linguistically competent service delivery, it is identified within the treatment plan.

Trauma Informed

A trauma informed approach to care is utilized throughout the course of services. Treatment planning and all aspects of documentation incorporate principles of safety, trustworthiness/transparency, collaboration, empowerment, and respect for cultural and gender differences. The assessment and treatment planning process demonstrate an understanding of the interconnection between cultural factors and the experience of trauma and trauma reactions. The treatment plan, as appropriate, addresses the impact of trauma



and associated behavioral health symptoms as well as resilience and protective factors for child and family/caregiver. Collaboration across providers and child serving systems in treatment planning and ongoing care addresses the prevention of re-traumatization.

Developmentally Appropriate

A recommendation for CFTSS is based on an assessment that is relevant to a child's stage of development. Services and interventions included within a treatment plan are provided in a manner that is not only appropriate for a child's age, but anchored to a child's developmental, social and emotional stage, and attuned to the relationship between the child and family/caregiver. As the child's needs indicate, the scope of service and interventions enable the family/caregiver's active involvement and are reflected in the plan. When the clinical focus of treatment indicates the parent/family or caregiver are needed as co-participants or for family-based interventions, this is reflected in the plan and implemented using interventions consistent with the child's stage of development (i.e. dyadic or attachment-based treatment for young children, or family-based interventions addressing needs related to family reunification, trauma, recovery, etc.).

Components – Required Elements

A treatment plan must include the following components:

1. Child's behavioral health diagnosis(es)*, where required; or behavioral health challenges/symptoms to be addressed;
2. Child's needs and strengths;
3. Child's goals and objectives (For FPSS, the service interventions/activities are directed to the parent(s)/caregiver(s) to support the needs of the child/youth. Therefore, goal(s) of the treatment plan are child/youth directed and the objectives and interventions/activities are targeted to the parent/caregiver in alignment with service function and scope);
4. Service(s), service components, interventions or activities necessary to accomplish the goals and objectives;
5. Projected frequency and duration of the services;
6. Location(s) where the service will be delivered;



7. Identification of individuals and/or other providers involved in the coordination, integration and/or implementation of services;
8. Safety Plan**;
9. Criteria for determining readiness for discharge from the service;
10. Name and title of the CFTSS staff providing the specific service;
11. Signature of the child and family/caregiver***, demonstrating their agreement with the plan and involvement in its development, and;
12. Signature of the licensed practitioner or licensed supervisor for OLP, CPST and PSR (for FPSS and YPS, licensed or credentialed supervisor) demonstrating review and approval of the plan.

The signatures of the parent, guardian, or other person who has legal authority to consent to health care on behalf of the child, along with signature of the child, where appropriate, are documented in the treatment plan. If the child or person with legal authority refuses or unable to participate or provide a signature, the reasons are documented in the plan. The child's family members and/or other collaterals who participate in the development of the treatment plan (as identified and agreed upon by the child/family) must be specifically identified in the plan.

** Behavioral health diagnosis(es) may be captured directly in the treatment plan or a notation indicating the diagnosis may be found in a specific assessment document within the case record must be indicated. Presenting challenges/symptoms and needs should be in accordance with the medical necessity admission criteria for a given service.*

*** The treatment planning process includes the development of a safety plan when indications of risk are identified for the child and/or family and must include safety measures that directly correlate to the risk symptoms and behaviors delineated in the treatment plan. Safety plans can serve as a separate standalone document but referenced within the treatment plan.*

****Follow family/caregiver signature requirements as indicated by lead New York State oversight agency.*



Timeframes

A treatment plan must be completed by the 4th session or no later than 30 days after admission (admission is the first session):

Tip: Specific to OLP, an evaluation for the purpose of determining eligibility - or for making a recommendation - can occur outside of an OLP “admission” and would not be considered part of treatment plan process, as these activities take place prior to enrollment. For instance, if an OLP Evaluation occurs to determine CFTSS eligibility, but the child/youth is not enrolled in ongoing OLP services, the child/youth would not be considered enrolled/admitted to OLP and a treatment plan is not required.

Upon admission to a service, the immediate need(s) of the child and family and plan for service provision are identified. While the provider, child and family engage in a more robust planning process in subsequent face to face sessions, the treatment plan may initially include only the most pressing, prioritized goal(s), objective(s) and intervention(s). Not all areas need to be addressed at one time, but a rationale should be provided if significant issues are not included in the treatment plan.

Once established, the treatment plan drives all subsequent documentation necessary for demonstrating the appropriate provision of services and the accuracy of billing. Services are provided in accordance with the interventions/activities, components and frequencies identified in the treatment plan and reflected accurately in progress notes upon service delivery.

Tip: *Treatment planning should be considered an ongoing process rather than a “moment in time activity.” The provider should engage families to continue developing more specific goals, objectives and interventions and to identify other participants needed to help them achieve their desired goals.*

Treatment Plan Review Schedule

A treatment plan review is due no later than 180 days from the previous treatment plan completion date:



A treatment plan review is a process to assess progress made toward achieving goals and objectives, while allowing for the review and adjustment of services/interventions necessary to assist the child and family. The treatment plan review reflects active and ongoing reassessment of the goals, objectives and discharge criteria, and demonstrates the need for continued care and appropriateness of the identified service(s).

At times, the treatment plan review may determine a need for additional or other services such as other rehabilitative or support services within CFTSS. The provider is expected to routinely evaluate and address changes in functioning, circumstances, and risk factors related to treatment goals by making the needed adjustments in goals, objectives, interventions or service recommendations.

Tip: *Adjustments to a treatment plan are made in collaboration with the individuals and providers involved in the coordination and/or integration of services. For providers to coordinate care using a collaborative, multidisciplinary team approach, involvement in the treatment plan review is expected. It is a means by which the providers, along with the child and family, can address the progress made in response to each respective service, the reassessment of current functioning and needs, and the needed adjustments to the treatment plan in a coordinated, complimentary manner.*

A treatment plan review must include:

1. An assessment of progress toward each goal and objective
2. The input of the child, family/caregiver, and any relevant providers or individuals involved in the treatment, on progress toward goals/objectives; current needs, strengths, or changes in preferences regarding services, interventions or participants.
3. Signatures or other indication of participation by the child, family/caregiver and service providers identified on the plan and involved in the child's treatment, demonstrating their agreement and involvement in the review. If the child/youth or person with legal authority refuses or is unable to participate or provide a signature, the reasons are documented in the plan.
4. The adjustment of goals, objectives, interventions, frequency, discharge criteria, and participants, as appropriate.
 - a. If determined a goal should be deferred or cancelled, the rationale is provided



5. The signature of the licensed practitioner or licensed supervisor for OLP, CPST and PSR (for FPSS and YPS, licensed, authorized, or credentialed supervisor) demonstrating their review and authorization of the plan

New goals, objectives and interventions are developed as the child/youth achieves prior objectives, or when there is little progress for an extended period. While treatment plan reviews are required at least every 180 days, the plan is revised when services are added or discontinued, or when circumstances warrant a change in goals, objectives, or interventions. This may include such circumstances as the emergence of new clinical issues or symptoms needing to be addressed; a crisis or sentinel event that impacts the child/family's life circumstances, relationships, etc.

Note: Targeted adjustments to the treatment plan do not replace a formal treatment plan review; a formal review must still occur within the required timeframe.

Treatment Plan - Supervisory Review

It is possible that a CFTSS treatment plan may involve multiple service providers and supervisors depending upon the structure of the agency. It is expected that these individuals will work collaboratively to reduce the burden on children and families and secure approvals and signatures in a timely manner. See section VII. Documentation: Supervisory Review for further information.

IV. Coordinated and Integrated Treatment Planning

CFTSS can be provided through a comprehensive, coordinated approach to wrap a variety of supports and services around families when needed. While admission to a CFTSS service is predicated on a child meeting the specific medical necessity criteria for the service, and each service has its own goals, objectives and interventions related to the child's needs; wherever possible, a treatment plan can be integrated to align the various services a child may be receiving to achieve coordination of care and collaboration amongst service providers. It is expected that service providers will readily communicate and coordinate interventions to facilitate integrated planning.

Collaterals such as other service providers or natural supports participating in the development of the treatment plan are specifically identified in the plan and considered part of the *multidisciplinary team*, along with the child and family/caregiver and provider



responsible for the plan. It is expected that CFTSS providers will collaborate and coordinate with providers outside of their respective agency to facilitate a coordinated approach to care and avoid service duplication. Coordination among providers involves deliberately organizing activities and sharing information among all participants concerned with a child's care. This means that the child and family's needs and preferences are communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care.

Tip: *When a child and family is receiving multiple CFTSS within the same agency, an integrated treatment plan is encouraged to help facilitate service integration and lessen the burden for families in managing multiple plans. The agency should consider the development of policies and procedures that support integrated treatment planning while also ensuring that accommodations be put in place when children and families do not agree to all aspects of the record being shared among all service providers (i.e. firewalls), in order to uphold their confidentiality preferences.*

V. Progress Notes

For every service delivered to a child, the provider must complete a Progress Note. Medicaid requires that service documentation be contemporaneous with service provision. Progress notes are completed when the provider delivers a direct service to the child, family or collateral, conducts coordination or collaborative contact with another provider including non-billable activities, or when significant events occur.

Tip: *Progress notes provide a narrative history of the child's progress including, recommendations or justification for changes or additions to current goals, objectives and methods/services of the treatment plan and describe newly identified strengths, needs, and barriers. Progress notes are often reviewed in audits for comparison against Medicaid billing claims. Providers should ensure progress notes be complete, contemporaneous, and accurate, and be related to and in accordance with, the services/interventions identified in the child's treatment plan.*



Components

Progress Note – Individual

To meet the standard for CFTSS, a Progress Note must document:

1. date of service;
2. location in which service was provided;
3. participants (to whom the service was provided);
4. interventions provided/utilized;
5. the child/youth's and family/caregiver's response to the interventions;
6. goal(s) and objective(s) that were addressed and progress made;
7. plan of action (e.g. plan for the continuing work; follow up plan needed to address any changes in functioning or symptoms; safety measures to be taken; rationale for changes or additions needed to current goals, objectives and interventions);

The following are standard data elements typically included in a program's Electronic Health Record (EHR) system. In the event these elements are not automatically generated, they must be included in the progress note documentation:

1. Standard demographic information (e.g., name, DOB, identification number, etc.)
2. type of contact (e.g., face-to-face);
3. modality (e.g., individual, family or group session);
4. service provided;
5. duration of service; (session start and end time e.g., 10:00am-11:00am) and;
6. name of person/agency providing the service



In addition to progress notes being completed to accompany any service procedure a provider delivers; a progress note must also be completed for any significant event and/or unexpected incident.

Tip: Best practice for documenting qualitative and responsible care includes the identification of new symptoms or changes in functioning presented by the child particularly indications of risk, a review of safety plan as applicable with the child/family, and the provider’s intervention, plan or actions taken.

When a provider recognizes the need for an assessment of risk and/or mental status (e.g. due to indication of elevated risk, or change in symptom while delivering a service), and it is not within the provider’s scope of practice to conduct such assessment, the provider should clearly document the actions taken to ensure linkage of the child/family to the appropriate resource, its outcome, and the follow up action needed or plan. Documenting the provider’s actions is not only a way of relaying a change in need during the process of treatment but also a way of demonstrating competent actions taken to facilitate safety.

When a provider coordinates care with other providers or significant individuals involved in the child’s care, the name(s) of person(s)/agency with whom services were coordinated is documented in the progress note.

Progress Note – Group

When entering group progress notes, in addition to the above, progress notes must clearly indicate “group” as the service modality provided, the number of participants (including any non-CFTSS children present or represented in the group) and number of service providers present. To deliver a group service, it must be clearly identified as an intervention in the treatment plan associated with the specific objectives.

A group progress note must be written for each group session and each participant for whom there will be billing and include all components listed above for individual service delivery.

VI. Safety Planning

When crisis activities or crisis-related services are being provided in any of the CFTSS, a safety plan (or crisis management plan*) is needed to support the child and family and guide



the interventions and activities. A safety plan is a tool for helping the child and family recognize and respond to personal vulnerabilities and life stressors in safe and effective ways. It contains a prioritized written list of management techniques, coping strategies and sources of support for a child and family to use before or during a crisis, or at any time the child or family recognizes an elevation of symptoms or indication of risk.

A safety plan is established when risk is indicated and created in collaboration with the child, family, service provider(s), those involved in the child's treatment and any additional resource or sources of support. Safety plans reflect the child/family's circumstances and preferences and may be modified over time. Typically, safety plans are developed as part of the treatment planning process when past and/or current risk factors indicate a likelihood of elevated risk, however may be developed at any point during service provision. Although typically utilized to assist children and families with elevated risk(s), this tool can be utilized to assist most individuals and families.

Safety plans provide a step-by-step plan to assist with the identification of triggers, warning signs of increased symptoms, management techniques for self-regulation, coping strategies to maintain safety within the family, home/environment, resources and supports with specific contact information (family and friends, professionals or agencies to contact for assistance).

Safety plans also serve as a communication tool across service providers and supports. The development of a new safety plan or the revision of an existing plan should be communicated and shared as soon as possible with collaborative providers and other identified supports involved in the child's treatment and care, with the family's consent. Providers should assist the child and family in recognizing its importance as a means of reinforcing the skills, strategies and supports needed to maintain safety and prevent escalation or crises.

Safety plans should be reviewed and updated following changes to the child's behavioral health, mental status including, but not limited to: change in available resources or supports, change in risk level or risk factors, change in symptoms/functioning, medication changes, precipitating events, hospitalization or discharge from hospital, etc.

** A crisis management plan is a comparable term to safety plan and included in the CFTSS manual. It is specifically identified within Crisis Intervention Services.*



VII. Discharge Planning

Discharge planning is an important element of service provision and a critical component of continuity of care. Discharge planning begins upon the child's admission to a service and continues to be updated throughout the course of service provision. At admission, the discharge criteria are identified and the plan for discharge is developed and further refined in conjunction with the treatment planning.

The discharge planning process serves multiple purposes including:

- Provides the child, family, and provider with a shared understanding of the changes needed to occur to indicate the service need/goals have been met and the child is ready for service discharge as agreed upon by all parties involved;
- Provides a basis by which the child, family/caregiver, and provider goal(s) monitor progress;
- Establishes a shared understanding between child, family/caregiver and provider of the therapeutic supports needed to reinforce or maintain the gains made by child and family, and the supports needed to prevent or address new problems from arising following discharge;
- Identifies and links the child and family to appropriate resources as next steps, based on their identified needs/preferences, which may also include addressing new or incomplete goals better addressed through alternative services

The discharge plan and expected date of discharge is reviewed by the provider team, including the child/, family/caregiver during the treatment plan review process. As progress is made over the course of service delivery, the team, along with the child and family, identify the needed services upon discharge.

Readying for Discharge

The planning process for discharge includes resources and supports beyond the child's current treatment team to include those with whom the child/family may be linked for step down, continuing care, or ongoing support. Strategic coordination and collaboration in discharge planning facilitates the ease and efficiency critical to continuity of care, and may include significant supports such as relevant school personnel, treating clinician, care coordinator, other community service providers, treating physician, in addition to any other natural supports identified by the child and family/caregiver, such as peers, relatives, and friends.



Tip: *Discharge planning can be a critical component to maintaining gains achieved during the course of treatment. A carefully developed discharge plan, produced in collaboration with the child/youth and family/caregiver will identify and match the identified needs with community resources, providing the support needed to sustain the progress achieved during treatment.*

Discharge Summary

A discharge summary can serve as a primary or standalone document to communicate to a receiving service provider the summary of care provided by CFTSS and the child and family's continuing care needs. At times, the discharge summary may be the only document requested to accompany a child and family to the next service provider.

A qualitative discharge summary includes the following elements and reflects comprehensive planning:

- Reason for discharge and efforts to reengage if discharge was not planned
- Service needs at discharge
- Services provided to the child/youth by the CFTSS agency
- Summary of progress towards treatment plan goals and objectives
- Referrals provided for on-going treatment and/or rehabilitative services
- Primary agency/provider to which individual is being discharged if applicable

Tip: *The following elements should also be considered for inclusion in the discharge summary to assist any other providers who may continue to serve the child:*

- *Primary or significant needs identified at time of admission and during treatment*
- *Assessment of child's level of functioning within the provider's scope of service at time of discharge*

Note: Providers should follow any internal agency policy and procedures in addition to other requirements set forth by State licensure, certification, and/or designation regarding the implementation and follow-up of discharge plans after the child/youth has been discharged from CFTSS.

VIII. Documentation – Supervisory Review

Supervision is an accountable process which supports and develops the knowledge, skills



and capacity of an individual in performing job functions and meeting responsibilities. Supervisors are expected to implement a process for review of documentation as a component of supervision to assure completeness, appropriateness, quality and compliance. The extent of review necessary is commensurate with the level of skill, quality and compliance of the staff in documenting.

The development of a CFTSS treatment plan requires the review, approval and signature of the licensed practitioner/supervisor (if different from the provider). The signature demonstrates that supervisory review and approval of the treatment plan has occurred, indicating the plan's appropriateness in addressing the presenting needs of the child and the specific service(s) to be provided. This implies, and reinforces, that a process of ongoing clinical supervision is occurring, as is necessary and critical in the delivery of safe, qualitative and effective care.

When issues of safety or indications of risk are apparent for any child or family which may include changes in the child's symptoms or mental status, the regular, consistent use of standardized tools to assess and monitor the level of risk severity should be clearly reflected in progress notes. Supervisors should also ensure the treatment plan reflects clinically appropriate interventions to target the risk symptoms and behaviors. When an assessment of risk necessitates immediate intervention to mitigate the risk, the supervisor ensures that responsive actions are taken by the provider to meet the immediate needs of the child, and that those actions have been promptly and clearly documented.

When risk is unknown, supervisors should ensure that a standardized risk screening tool is routinely utilized, and its usage documented, particularly when a child experiences a change in status such as transition in level of care, return to home and community from an inpatient setting, change to a new provider, or is impacted by a potential new risk factor.

Documentation reflects adherence to the agency's policy and procedures for addressing issues of risk, including such aspects as the method used for assessing severity of risk, the use of identified supports and protective factors to mitigate risk, the linkages made to the appropriate resource, the outcome of interventions provided and the identified plan or follow up actions to be taken.

Supervisory guidance and review of both the provider's actions in these circumstances and the way they are documented, should be routine, ongoing, and reinforce an agency-wide policy for addressing issues of risk. The agency's policy should include the use of routine,



sound clinical approaches to risk screening, assessment and targeted interventions as a way of building staff competencies to address risk symptoms and behaviors, and the demonstration of clinical diligence reflected through sound documentation practices. The use of a standardized progress note format may also be considered by agencies to facilitate consistency among providers and the inclusion of pertinent elements when documenting service delivery.

Each CFTSS provider agency is expected to develop and implement a quality assurance process to facilitate improved documentation practices. The overall documentation of each staff is periodically reviewed, including all aspects of the health record, to identify strengths and needed areas for development and training. Corrective action should follow as needed to include how the areas for development will be addressed, such as through training and/or increased monitoring, and a time frame for completion.

IX. Additional Documentation

A health record may include information relevant to a child/youth's behavioral and medical health history, including past and present diagnosis(es), assessments, treatments, and outcomes to provide context for the medical necessity recommendation. Additionally, the health record should include information regarding emergency medical information (e.g., child/youth's treating physician, currently prescribed medications, medication and food allergies, etc.) and made readily available in the event of an emergency situation.

The health record also records necessary documentation that illustrates activities associated with orienting and admitting a child/youth and family/caregiver to CFTSS. The following should be evidenced through documentation within the health record upon an individual's admission to a CFTSS:

- a. consent to receive service(s)
- b. acknowledgement/receipt of HIPAA, having been explained and orientation to service information
- c. acknowledgement of freedom of choice having been explained and offered the ability to choose a provider within the child's network of providers
- d. acknowledgment /receipt of individual's rights, having been explained (including the right to file grievances)

CFTSS provider agencies should have clear protocols to support the rights and protections of children and youth and families who are receiving services or have received services. An



agency's protocols should meet the requirements of the lead agency by whom it has been licensed, certified, authorized or designated and should be evidenced through its documentation.

Note: CFTSS Designated Agencies are responsible for ensuring adherence to applicable federal and state laws and requirements pertaining to Health Record retention, confidentiality, and Medicaid billing.

Licensed Practitioner of the Healing Arts (LPHA) Recommendation

Each enrolled child must have an LPHA Recommendation confirming medical necessity for the identified service(s). CFTSS provider agencies are required to maintain a LPHA Recommendation for all enrolled services within the child's case record. For more information, specific to CFTSS medical necessity or LPHA Recommendation, refer to the [CFTSS Provider Manual](#).

*If a licensed practitioner (OLP) conducts an evaluation to determine the need for ongoing OLP services, an admission note must be written which includes reason for referral, primary clinical needs, and OLP services to meet those needs.

X. Appendix

The following is intended to be helpful guidance, provided specifically to address the challenges frequently experienced by providers in developing clear, meaningful treatment plans as a core element of service delivery, documentation and billing.

I. Goals, Objectives and Interventions

Establishing functional, meaningful and child centered, family driven goals and objectives are essential in facilitating and assessing the child and family's progress. Goals, objectives and interventions are fluid and change as the strengths, needs, functioning and preferences of the child and family change. Additionally, they elicit opportunities within the everyday routines and activities of the child and family's life to promote or rebuild strengths and competencies.

Goals

A goal is an individualized, general statement of outcome, related to an identified need based on an assessment. Goals start with the child and family's priorities; what they consider to be



their strengths and most pertinent needs in relation to the service. In setting goals, it is important to consider the functional areas to be addressed as well as considering what is already working well in the child and family's lives to build upon and assist in addressing these goals.

Goal setting is a collaborative process that offers an important opportunity to partner with the child/youth and family/caregiver to engage and empower them in setting self-defined goals. This is demonstrated by including the child's and/or family/caregiver's words or ideas, when appropriate, within the written goals. A goal statement takes a particular identified need and answers the question "What do we want the outcome of our work together to be as we address this identified need? What does success look like?" A goal is therefore broader than an objective and is tied to discharge.

Objectives

Objectives are the achievable steps toward the accomplishment of a goal and are expected to be attained from the planned interventions. An objective is realistic, specific, and targets change in symptoms, behaviors, functioning skills, knowledge, etc. Attainment of objectives can demonstrate achievement of the goal.

In tying directly back to the goal, objectives contain specific steps to ensure that progress can be measured. Objectives can be thought of as milestones; not just things the child will do. They should identify what behavior/action the child will demonstrate and how it will be measured. Some objectives are easy to measure and for the child and family to report on, such as demonstration of skills/strategies, while others are better assessed with the use of self-tracking tools or scales, such as symptom or behavioral changes. The more realistic or natural the objective, such as involving a routine in the daily life of the child/family that is impacted by the symptoms or behaviors, the more applicable it will be to everyday situations and reinforce a generalization across settings.

Interventions

An intervention is a specific type of service modality provided that describes the clinical strategy, method, or action delivered by the provider to assist the child and family in attaining the identified objectives. It describes the skilled interventions or approaches used to assist the child and family in achieving objectives. Not only should interventions identify the specific service type and skilled strategy or approach (e.g., individual therapy using a cognitive behavioral approach) but also should identify the expected frequency and duration of the service to be provided.