Psychiatric Residential Treatment Services Guidelines

Provider shall administer enhanced Wraparound services, which means a definable, team-based planning process involving a Member 0-17 years of age (or young adult Members who wish to continue receiving Wraparound services) with complex behavioral health problems who receives Psychiatric Residential Treatment Services (PRTS), and their families. Provider likewise will ensure care coordination for these Members.

Provider shall participate in Child and Family Team meetings to occur no less frequently than every 14 days, and may occur more frequently. Individualized Plans of Care shall be developed by the child and family team, and subsequent revisions will be done at least every 14 days and as needed. Child and family teams will include: family Members including involved biological family Members, or foster parents, the Health Share Care Coordinator, representatives from the school district or appropriate Education Services District, involved Providers and agencies such as Child Welfare, the child when appropriate, and any other natural, formal, and informal supports as identified by the family.

A comprehensive mental health assessment will be completed for each resident that includes all relevant domains and includes strengths and needs assessment within each domain. Services shall be based on the comprehensive mental health assessment, shall be culturally and linguistically appropriate and reflect an understanding of the unique cultural background of the child and family, and shall be individually tailored in type, level and intensity to meet the individual Member and family's needs. Individual service plans shall be developed and integrated with the Plan of Care provided by the Health Share Care Coordinator. Service plans shall reflect integration of Provider's clinical model and incorporate skill development, treatment that addresses the family system, and family involvement and education.

Provider will demonstrate a philosophy of families as equal partners and include families in all phases of assessment, treatment and discharge planning, which will be evidenced by documentation in the clinical record, feedback from families and system partners, and/or interviews with treatment team Members and agency staff. Families and Members will be educated on the Provider's clinical model and be provided assistance in generalizing learned skills to the home and community setting. Provider will have policies and procedures in place that support family involvement and identify, address and prevent barriers to their participation in treatment.

Active, focused discharge planning will be provided beginning at the date of admission which will link the child to appropriate community-based services delineated in the plan of care, coordinate care with pre-admission and post-admission Providers and agencies, and develop and implement discharge plans. Discharge and transition planning will be done in collaboration with the Health Share Care Coordinator. Discharge planning shall include applicable education service district or school district to coordinate and provide needed educational services for the

children after discharge. School districts shall be notified in advance of all discharge planning meetings and have at least 14-day notice of a child enrolling in their district (or as soon as length of stay permits). In the event that a child is discharged unexpectedly, Provider will make every effort to coordinate with the receiving school district to facilitate a smooth transition. Discharge instructions shall be part of the information given to the parent or guardian upon or prior to discharge. Discharge instructions include diagnosis, current medication and medical information, community treatment appointments and Provider information. In addition, Provider will ensure that intervention strategies to manage the child are given to the parent or guardian at the time of discharge and in language the caretaker can understand, prior to receiving a discharge summary. Prior to discharge, Provider will ensure that family/guardian has a written safety plan developed by Provider or Member's community treatment Provider.

Services are to be evidence-based and include promising practices whenever evidence exists appropriate for children with severe mental, emotional, or behavioral disorders. Specific services to include: milieu treatment integrated with individual services and supports plan; psychiatric assessment; medication evaluation and management; individual, group and family therapy; multi-family treatment group; parent and child skills training; pre-vocational/vocational rehabilitation; speech, language and hearing rehabilitation services; behavior management; activity and recreational therapy; nutrition; physical health care services and coordination; interpreter services; case management; clinical services coordination; and consultation. Provider will ensure that admitted youth have at least weekly access to psychiatry and medication evaluation and management.

Provider will develop written agreements with DHS Child Welfare, Oregon Youth Authority and the Juvenile Department to include expectations for coordination/communication. Minimally, these communications should include monthly treatment progress reports. If a child's Service Coordination Plan indicates DHS or OYA placement is required at discharge, DHS or OYA shall be informed of the plan on admission or as soon as the placement need is identified (minimum of 30 days prior to the planned discharge date).

Provider shall inform Health Share and the child's legal guardian within one working day of reportable incidents as defined in OAR 309-022-0105(77).