Disclaimer: The following text is meant to be a guideline in establishing general provisions for specific programs for certification requirements of the Child And Youth Behavioral Health Services (Blue Book). The document will need to be tailored to reflect your agency's program. Please note the many areas that prompt you to put the name of your specific agency in the parenthesis.

(The Agency)
GENERAL PROVISIONS

CRIMINAL RECORDS CHECKS AND CLEARANCES

7.20.11.15. A (The Agency) will initiate and provide to the Department two completed State-and FBI-approved fingerprint cards for each employee who will serve as direct services staff. The criminal records clearance will be from Family Services Community and Behavioral Health Services, Licensing and Certification prior to the employee's direct, unsupervised contact with clients of the program. Non-compliance with this requirement may result in sanction up to loss of certification as referenced in NMSA 1978 32A-15-3.

B.(The Agency) will comply with 8.8.3 NMAC Regulations governing criminal records checks.

C. Student trainees in psychiatry, psychology, social work and/or nursing, or other related health, social or human-services disciplines who are enrolled in a clinical training program of a New Mexico State accredited institution of higher learning, and who are under the supervision of a cleared licensed independent practitioner, may be allowed to work with children without direct physical supervision during their enrolled student tenure if the trainee signs a sworn affidavit attesting that he or she has never been convicted of a crime that would disqualify him or her from providing direct services to children.

D. The Certification Requirements governing criminal records clearances remains in effect while a program is accredited by COA, CARF or JCAHO.

E. If a prospective employee has not lived in the United States continuously for the five years previous to hire, the equivalent of a criminal records clearance is required from any country in which he/she has lived within the last five years, for a period longer than one year.

F. If the agency receives reliable evidence that indicates that an employee or prospective employee poses a potential risk of child abuse, sexual abuse, exploitation, moral turpitude, cruelty, or indifference to children, the agency is in violation of these Certification Requirements and subject to sanction up to loss of certification if that individual is hired or retained.

G. Upon request by the LCA, the agency will provide a list of employees who are not required to have a criminal records clearance, and the reason why not.

H. Non-compliance with any Certification Requirement relating to criminal records checks and clearances may result in sanction or loss of certification. In addition to the foregoing, the following Certification Requirements relate to criminal records checks and clearances:

(1) 16.G.1(f) concerning prospective employee history verification and reference checks;
(2) 16.G.1(h) concerning letters of attestation for employees pending clearances;
(3) 16.G. 2 concerning disclosure of arrests/convictions;
(4) 16.H.1-5 concerning staff schedules.

PERSONNEL

7.20.11.16 A. (The Agency) provides personnel who are trained, supervised and in all respects qualified to perform the functions for which they are responsible. A full and complete employment history will be completed. (The Agency) will verify employment for all staff including names, address, and telephone numbers of employers, immediate supervisors as well as dates of and explanations for any period(s) of unemployment for a minimum of three years prior to hire.

B. Each position, or group of like positions, is detailed in a written job description that clearly

states qualifications, responsibilities and requirements.

C. Each agency employee meets all State Registration, Licensing and/or Certification Requirements applicable to his or her position and/or use of professional title(s) and the agency has copies of such licenses, etc. on file.

ORIENTATION OF PERSONELL

7.20.11.16 D (1)The agency orients its personnel to the agency's goals, services, policies and procedures, and to the responsibilities of the staff member's position. Initial and ongoing orientation is documented in the personnel record.

(2)Orientation includes training on the establishment and maintenance of appropriate and responsive relationships and boundaries with clients.

PERSONNEL TRAINING, DEVELOPEMENT, RESPOSIBILITIES AND SUPERVISION

7.20.11.16.E (1) The agency provides a training and development program to allow personnel to improve their knowledge, skills and abilities and to promote awareness and appreciation of the cultural background and need of persons served by the agency. This training will be documented in the personnel file.

(2) The agency provides staff development opportunities for personnel, including in-service training.

(3) Staff who require training to qualify for a position in which they are responsible for the care of children do not have sole responsibility for the care of children until after the successful completion of the training.

(4) Staff designated as direct service staff under service-specific Certification Requirements receive ongoing training related to the age and/or emotional development of the children for whom they are responsible.

(5) All certified services are provided under supervision of a clinical director who provides clinical oversight of the program, by way of documented supervision and consultation to all agency staff. Supervision may be direct, or may occur through a clinical supervisor who is directly supervised by the clinical director.

(6) All clinical supervision/consultation is documented and documentation includes the theme, date, length of time of supervision and signatures of those participating.

(7) In the event that the therapist and clinical supervisor are the same person, another properly credentialed clinician, either from within the agency or from outside the agency, provides supervision at least one time per month to the clinical supervisor.

(8) The responsibilities of the therapist include providing therapy and participating in the development of a treatment plan. These activities are documented.

(9) If (The Agency) utilizes the services of professionals on a per interview, hourly, part-time, or independent contractor basis, the agency documents regular assessment of the quality of services provided.

ACCOUNTABILITY

7.20.11.16F (1)(The Agency) ensures that the performance of all employees, consultants, contractors, and volunteers is consistent with agency policy and these Certification Requirements.

(2) At least once a year, written performance reviews are conducted jointly between each staff member, including volunteers, and the person's supervisor.

PERSONNEL RECORDS

7.20.11.16 G (1) A personnel record is maintained for each employee and volunteer. Each personnel record is readily accessible to the LCA at each site visit, and contains, at a minimum:

(a) Documentation of all orientation and training, including dates, hours or credits, names of trainer and trainee, and written confirmation by trainer or training organization that the training has occurred;

(b) Employee's name, current address, telephone number and emergency contact(s);

(c) Job title and description;

(d) Evidence of licensure for those employees required to be licensed;

(e) Date first employed and dates of transfers or changes in position;

(f) Documentation of a minimum of three employment reference checks within three weeks prior to employment (if this process yields fewer than three employment reference checks, additional professional and/or personal references are obtained to achieve the required minimum of three references);

(g) A copy of the employee's current CPR and first aid certificates;

(h) For cleared staff, the criminal records clearance letter, or for uncleared staff, a signed statement by the administrator, director, or operator attesting to direct supervision of the uncleared employee by a cleared employee until the clearance is received;

(i) Application for employment or resume consistent with agency policy;

(j) Performance reviews, as applicable;

(k) A current certificate stating that the employee is free from tuberculosis in a transmissible form, obtained prior to the first date of direct service, as required by the New Mexico Department of Health regulations, Control of Communicable Disease in Health Facility Personnel, 7.4.4 NMAC.

(2) (The Agency) written policies and practices require that an applicant for employment disclose any prior criminal convictions, and employees report any arrests and/or convictions that occur while employed.

Each personnel record is readily accessible to the LCA at each site visit, and contains, at a minimum:

(a) Documentation of all orientation and training, including dates, hours or credits, names of trainer and trainee, and written confirmation by trainer or training organization that the training has occurred;

(b) Employee's name, current address, telephone number and emergency contact(s);

(c) Job title and description;

(d) Evidence of licensure for those employees required to be licensed;

(e) Date first employed and dates of transfers or changes in position;

(f) Documentation of a minimum of three employment reference checks within three weeks prior to employment (if this process yields fewer than three employment reference checks, additional professional and/or personal references are obtained to achieve the required minimum of three references);

(g) A copy of the employee's current CPR and first aid certificates;

(h) For cleared staff, the criminal records clearance letter, or for uncleared staff, a signed statement by the administrator, director, or operator attesting to direct supervision of the uncleared employee by a cleared employee until the clearance is received;

(i) Application for employment or resume consistent with agency policy;

(j) Performance reviews, as applicable;

(k) A current certificate stating that the employee is free from tuberculosis in a transmissible form, obtained prior to the first date of direct service, as required by the New Mexico Department of Health regulations, Control of Communicable Disease in Health Facility Personnel, 7.4.4 NMAC.

(1) (The Agency) written policies and practices require that an applicant for employment disclose any prior criminal convictions, and employees report any arrests and/or convictions that occur while employed.

(2) Each uncleared employee is identified on the staff schedule.

(3) The staff schedule is updated daily to reflect actual hours staff are present and changes in attendance as they occur.

(4) Original updated staff schedules are kept on file for at least 12 months.

(5) The updated schedule documents the client census for each unit of a Residential Treatment Services Center or Group Home Service on a daily basis.

ALLEGATIONS OF ABUSE/NEGLECT, COMPLAINTS, AND SERIOUS INCIDENT REPORTING:

7.20.11.17 A.(The Agency) maintains and follows policies and procedures consistent with these Certification Requirements for timely reporting of any serious incidents and allegations of abuse or neglect. The agency immediately reports allegations of abuse or neglect to all appropriate entities, including but not limited to the Protective Services Division of the Department via Statewide Central Intake/Tribal Social Services Agency, the client's legal guardian, the jurisdictional law enforcement agency, and the LCA.

B (The Agency) reports all serious incidents to the LCA by fax within 24 hours of any staff member becoming aware of the incident or allegation of incident. Incidents involving minor illnesses or injuries not requiring emergency services do not need to be reported to the LCA. Day Treatment Services, Home-Based Services, Case Management Services, and Behavioral Management Skills Development Services are not required to report serious incidents that do not occur during program hours, with the

exception that all deaths must be reported.

C Additional Reporting Requirements for Deaths: Deaths are reported to the LCA immediately by telephone and followed by fax within 24 hours, whether or not the death occurs during program hours. Agencies are required to report any client death to the regional office of the federal Centers for Medicare and Medicaid Services by no later than by the close of business the next business day after the client's death, and must document in the client's record that the death was reported to the Centers for Medicare and Medicaid Services.

D. Each serious incident report is written by the staff who have personal or firsthand knowledge of the incident/allegation, and is signed and dated by that person(s). Once written, the report is not altered, but may be amended. Any amendment is signed and dated by its author and filed with the original report. The report clearly distinguishes between events witnessed by the reporter and statements made to the reporter. The report contains, but is not limited to the following information regarding the incident: date, time, and location of the incident, behavioral description(s) of relevant event(s), descriptions of health/safety risk(s) relevant to the incident, identification of person(s) present, birth date(s) of client(s) involved, level of care of the client(s) involved, initial actions in response to the incident, names of persons providing information to the reporter, and identification of other entities receiving the report.

E. Each serious incident for which a report to the LCA is required herein and that involves possible criminal activity is reported immediately to the appropriate law enforcement agency.

F (The Agency) responds in a timely manner to protect its clients from physical or psychological risks of which it is or reasonably should be aware, in order to reduce and prevent future risks.

G. Outcomes, dispositions, and descriptions of any voluntary corrective action(s) taken by the agency in response to serious incidents are faxed or mailed to the LCA in a timely manner.

H. The program will not rely on the fact that it has made a serious incident report to the LCA, or the fact that it may not have received a response from the LCA, to delay appropriate corrective or protective action in response to an incident.

I.(The Agency) maintains and follows policies and procedures for investigating and responding to allegations of abuse or neglect in a confidential and timely manner.

J.(The Agency) maintains and follows policies and procedures for investigating and responding to complaints in a timely manner.

K.(The Agency)provides a written response, in a timely manner, to the complaining party and, as applicable, the parent, legal or treatment guardian, regarding the resolution of each complaint or allegation.

(The Agency) IN THE COMMUNITY

7.20.11.18 A.(The Agency) identifies a defined purpose, uses a multi-disciplinary approach in which services are coordinated within the agency and within the provider community, and collaborates with other agencies in provision of services for its clients.

B.(The Agency) statement of purpose includes a description of its primary function as providing services that:

(1) Serve those clients in need of treatment who are most vulnerable or at risk;
(2) Are habilitative in focus; and
(3) Are consistent with the least restrictive means principle.

C. Community Access to Services:

(1) (The Agency) provides culturally competent services and serves the needs of those clients who are bicultural and/or who are non-English speaking through the use of:

(a) Bilingual/bicultural professional and qualified paraprofessional personnel;
(b) Translators to meet the clients' communication needs.

(2) (The Agency) provides public information concerning its services to persons in the community who are non-English-speaking. This information is designed to encourage full participation of non-English speaking clients.

(The Agency) GOVERNANCE AND ADMINISTRATION:

7.20.11.19 A.(The Agency)is legally authorized to operate, identifies the members of its governing body, and administers its program in accordance with its own policies, which support compliance with these Certification Requirements.

B. The governing body is responsible for adopting bylaws and policies and defining the scope of

its services. The agency is legally authorized to operate as one of the following:

(1) Not-profit agency, incorporated in the state in which it operates, with a charter, constitution, and by laws;

(2) Not-profit agency operated by its own independent governing body, under the aegis of a religious body or other organization recognized under the laws of the State;

(3) Public agency authorized and established by statute, or a sub-unit of a public agency with which clear administrative relationship exists;

(4) Proprietary agency organized as a legal entity as a corporation, partnership, or association, but excluding there from sole proprietors; or

(5) Agency of a tribal government, or subdivision thereof.

C. Policies and procedures: The agency maintains a manual containing current policies and procedures for agency administration, service delivery, and protection of consumer rights.

(1) (The Agency) makes a copy of its policies and procedures manual available to new personnel upon employment.

(2) (The Agency) documents that it keeps all personnel advised regularly of revisions to its policies and procedures manual as revisions occur.

(3) (The Agency) conducts annual reviews of its policies and procedures and makes revisions as necessary to maintain compliance with applicable laws, regulations, and these Certification Requirements.

QUALITY IMPROVEMENT AND UTILIZATION REVIEW:

7.20.11.20 A.(The Agency) has a continuous quality improvement process, reviewed annually, through which the agency systematically evaluates the effectiveness of services provided by determining whether its services meet pre-determined quality improvement expectations and outcomes, and corrects any observed deficiencies identified through the quality improvement process.

B.(The Agency) explicitly details the desired expectations and service outcomes for each of its programs and has a written plan to achieve them.

C.(The Agency) establishes a committee or other mechanism for the timely and regular evaluation of serious incidents, complaints, grievances, and related investigations. Committee evaluations include identification of events, trends and patterns that may affect client health, safety, and/or treatment efficacy. Committee evaluation findings and recommendations are documented and submitted to agency management for corrective action. Actions implemented and outcomes are documented, and trends are analyzed over time. The agency has a well-defined plan for correcting problems. When problems (or potential problems) are identified, the facility acts as soon as possible to avoid any risks to clients by taking corrective steps that may include, but are not limited to:

(1) Changes in policies and/or procedures;
(2) Staffing and assignment changes;
(3) Additional education or training for staff;
(4) Addition or deletion of services.

D. The agency develops a system to utilize its collected data regarding the outcome of its activities for delivering continuously improving services.

E. Formal and informal feedback from consumers of services and other collateral sources is aggregated and used to improve management strategies and service delivery practices.

F. The agency collects and maintains information necessary to plan, manage, and evaluate its programs effectively. The outcomes are evaluated on a quarterly basis, the results of which are used continuously to improve performance.

G. The agency implements and maintains ongoing utilization review processes.

LEGAL, REGULATORY, AND ACCREDITATION COMPLIANCE FOR PROGRAM OPERATION, INCLUDING HEALTH, SAFETY AND PHYSICAL PLANT REQUIREMENTS:

7.20.11.21 A.(The Agency) promotes and protects the health and safety of its clients, demonstrates compliance with all applicable laws and regulations, adheres to the requirements of its accrediting bodies, if any, and possesses all applicable licenses required by law and Departmental policy.

(1) License(s) Required: (The Agency) possesses a license(s) and complies with applicable licensing requirements for each service required by State and local law and Departmental Regulation including, but not limited to the following:

(a) Each treatment foster care child placement agency is licensed by the Protective Services Division of the Department as a child placement agency.

(b) All Residential Facilities are licensed by the Department. Each maintains a separate license.

(c) Day Treatment Services are licensed as Day Treatment Centers by the Department. Each Day Treatment Services facility maintains a separate license. Exception: Day Treatment Services provided in a public school facility do not require licensure by the Department.

(2) Residential Treatment Services and Group Home Services are certified only when provided in a facility licensed by the LCA for 16 beds or fewer per unit.

B. An agency accredited by an accrediting organization recognized by the LCA complies with the current requirements of the accrediting organization. The accrediting organizations recognized by the LCA are:

(1) Council on Accreditation for Children and Family Services (COA);

(2) Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and

(3) Council on Accreditation of Rehabilitation Facilities (CARF).

CLIENT PARTICIPATION, PROTECTION, AND CASE REVIEW:

7.20.11.22 A.(The Agency) takes all reasonable action(s) to protect the health, safety, confidentiality, and rights of its clients. The agency informs the client of his or her rights and responsibilities and develops and implements policies and procedures that support and facilitate the client's full participation in treatment and related agency activities. The agency protects the confidentiality of client records through adherence to its own set of policies and procedures governing access to, and release of, confidential information.

B. Materials describing services offered, eligibility requirements and client rights and responsibilities are provided in a form understandable to the client and client's legal guardian(s) with consideration of the client's/guardian's primary language, and the mode of communication best understood by persons with visual or hearing impairments.

(1) If the client is unable to understand the materials for any reason, every effort is made to explain his or her rights and responsibilities in a manner understandable to the client. These efforts will be documented in the client's record.

(2) Materials are available or posted in the agency's reception area and/or handed to potential clients during their initial contact with the agency.

C. (The Agency) explains to each client what his or her legal rights are in a manner consistent with the client's ability to understand and makes this information available to the client in writing, or in any other medium appropriate to the client's level of development. A written explanation of these rights is given to the parent/legal guardian upon admission.

(1) A client who receives Residential Treatment Services has the rights enumerated in the New Mexico Children's Mental Health and Developmental Disabilities Code, NMSA 1978, Sections 32A-6-1 et seq. (1995). Explanation of rights to the client and parents/legal guardian is documented in the client's record.

(2) (The Agency) maintains and follows written policy affirming that clients may refuse any treatment or medication, unless the right to refuse treatment(s) has been limited by law or court order. The agency informs the individual of the risks of such refusal. Client refusal of treatment and advisement of risks of the refusal is documented in the client's record.

(3) (The Agency) specifies in written policies and procedures the conditions under which it serves minors without parental/legal guardian consent, and when parental/legal guardian consent is not possible, designates who is authorized to give consent to treat the minor.

(a) The client record contains all applicable consents for treatment, including consent for emergency medical treatment and informed consent for prescription medication.

(b) Exception: Day Treatment Services, Home-Based Services, Behavioral Management Skills Development Services and Case Management Services programs are not required to file consents for prescription medications that are not taken during program hours unless the medications are prescribed by a program physician.

(c) Consent forms must contain the information identifying the specific treatment, prescription medication, information release, or event for which consent is being given prior to being signed by a client or guardian.

(4) Upon admission, each client receives an orientation to the agency's services that includes the basic expectations of the clients, the hours during which services are available, and any rules established by the agency regarding client conduct, with specific reference to behavior that could result in discontinuation of a service. Orientation of the client and parents/legal guardians is documented in the client's record.

(5) (The Agency) maintains a written grievance/complaint procedure that is reviewed with the client and parent/legal guardian upon admission. The client's record contains documentation of the agency's explanation of the grievance procedure to the client and the parent/legal guardian.

(6) Financial arrangements are fully explained to the client and/or his or her parent/legal guardian upon admission, and at the time of any change in the financial arrangements.

(7) Procedures for protecting Client Assets: The agency establishes and follows written policies and procedures to identify how it manages, protects, and maintains accountability for client assets, including the segregation of client funds when an agency assumes fiduciary responsibility for a client's assets and/or disburses funds such as maintenance or allowance funds to clients.

(8) The agency establishes written procedures for providing client access to emergency medical services.

(9) Written agency policy specifies clinically appropriate and legally permissible methods of behavior management and discipline and provides training in their use to all direct service staff. The agency prohibits in policy and practice the following:

(a) Degrading punishment;

(b) Corporal or other physical punishment;

(c) Group punishment for one individual's behavior;

(d) Deprivation of an individual's rights and needs (e.g., food, phone contacts, etc.) when not based on documented clinical rationale;

(e) Aversive stimuli used in behavior modification;

(f) Punitive work assignments;

(g) Isolation or seclusion, except as delineated in Section 24;

(h) Harassment; and

(i) Chemical or mechanical restraints, except as delineated in Section 24.I.

(10) (The Agency) establishes and follows written policies and procedures for the use of therapeutic time-out in accordance with these Certification Requirements, including the following directives:

(a) Therapeutic time-out can only be used for the length of time necessary for the client to resume self-control and/or to prevent harm to the client or others;

(b) Therapeutic time-out is not used as a means of punishment;

(c) Therapeutic time-out is not used for the convenience of staff; and

(d) Therapeutic time-out is monitored closely and frequently to ensure the client's safety.

D. (The Agency) prohibits the use or depiction of individuals (residents, clients, etc.), either personally or by name or likeness (e.g., photograph), in material (photographs, videotape or audiotape), presented in a context that is either commercial or public service oriented in nature. An exception to this prohibition applies to children presented on the "Wednesday's Child" television program, Los Ninos or other adoption exchange publications, in which case any participation and presentation is in accordance with the Department's rules and regulations and with the knowledge, consent and active participation of the Department.

E. Client Information and Case Review: The agency maintains records and follows policies and procedures governing the access to, and release of, confidential information. The agency provides adequate facilities for the storage, processing and handling of clinical records, including suitably locked and secured rooms.

(1) The agency's written policies govern the retention, maintenance, and destruction of board administrative records, and records of former clients and personnel. These policies address:

(a) Protection of the privacy of former clients and personnel; and

(b) Legitimate future requests by former personnel or clients for information, particularly information that may not be available elsewhere.

(2) The agency has policies governing the disposition of records, security of records and timely access and retrieval of records in case of the agency's dissolution. The retention of records is required for the later of:

(a) Four years after the client is released from treatment; or

(b) Two years after the client reaches age 18; or

(c) Two years after a client has been released from most recent legal guardianship, and is no longer under legal guardianship.

(3) The agency specifies in written policies and procedures how it releases information. Any release is in accordance with applicable State and federal laws. The agency does not request or use any information release form that has been signed by a client, parent, guardian or other party prior to pertinent information being completed on the form.

(4) In the event of a medical emergency that warrants immediate intervention in order to protect the life or safety of the client, access to information regarding the client's diagnoses and treatment plan/service plan may be provided to medical personnel.

F. Contents of the Client Record:

(1) Agency policy defines information to be contained in the client record. At the time of admission, the client's date of admission to each and any certified service is documented in a consistent location in the client record.

(2) Agency policy and practice provide that entries in the client record are made in an accurate, objective, factual, legible, timely, and clinically-based manner.

(a) Entries made in the client record pursuant to these Certification Requirements clearly identify the person completing the entry and his or her credentials.

(b) Late entries are identified as such; late entries include the actual date of the entry and the signature of the person completing the entry.

G. When prescribing medication or other treatments, the prescribing professional documents the indication for any medical procedures and/or prescription medications.

(1) When a client is seen by the prescribing professional, subsequent to a medical prescription or treatment, the professional documents the response to the prescription or treatment and any observed side effects.

(2) Medication, including non-prescription medication that is administered by a nurse or is self-administered, is documented by the agency staff with the date and time of administration, the name and dosage and any side effects observed.

H. A written discharge summary is placed in the client's record within 15 days of termination of services and includes:

(1) Clinical and safety status;

(2) Medications being taken at discharge;

(3) Documentation of notification to Primary Care Physician;

(4) Specification of referrals/appointments made with specific names;

(5) Target behaviors addressed;

(6) Services provided;

(7) Progress attained, or lack thereof;

(8) Description of interventions to which the client did and did not respond, including medications;

(9) Recommendations for continued treatment and services.

I. Client Review of Case Record:

(1) An individual may review his or her case record in the presence of a therapist or Licensed Independent Practitioner of the agency on the agency's premises unless to do so would not be clinically indicated. The reasons why review is not clinically indicated are documented in the client's record. The confidentiality of other individuals is protected.

(2) The agency's policies and procedures allow the client to insert a statement into the record about his or her needs or about services he or she is receiving or may wish to receive. Any agency statements or responses are documented with evidence that the client was informed of insertion of such responses.

INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARE PLANNING, AND DISCHARGE:

7.20.1123 A. The agency establishes criteria for admission, conducts ongoing clinical assessments, and develops, reviews, revises treatment plans and provides ongoing discharge planning with the full participation of the treatment team.

B. Clinical decisions are made only by qualified clinical personnel.

C. Intake and Screening:

(1) The agency establishes and follows written criteria for admission to its program(s) and service(s), including Exclusionary criteria.

(2) The agency establishes and follows written intake procedures to address clinical appropriateness for admission.

(3) The agency's eligibility criteria are consistent with EPSDT requirements and Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC.

D. Assessments: The following applies to all certified services, except Case Management Services. Each client is assessed at admission and reassessed at regularly specified times to evaluate his or her response to treatment, and specifically when significant changes occur in his or her condition or diagnosis. The assessment process is multidisciplinary, involves active participation of the family or guardian, whenever possible, and includes documented consideration of the client's and family's perceptions of treatment needs and priorities. Assessment processes include consideration of the client's physical, emotional, cognitive, educational, nutritional, and social development, as applicable. At a minimum, the following assessments are conducted and documented:

(1)An initial screening, conducted at admission, of physical, psychological, and social functioning, to determine the client's need for treatment, care, or services, and the need for further assessment; and assessment of risk of behavior that is life threatening or otherwise dangerous to the client or others, including the need for special supervision or intervention.

(2) A full EPSDT screen (Tot-to-Teen Health check) within 30 days of the initiation of services, unless such an examination has taken place and is documented within the 12 months prior to admission. The documented content of the history and physical examination must meet EPSDT requirements.

(3) (The Agency) conducts a comprehensive assessment of each client's clinical needs. The comprehensive assessment is completed prior to writing the comprehensive treatment plan, and includes the following:

(a) Assessment of the client's personal, family, medical and social history, including:

(i) Relevant previous records and collateral information.

(ii) Relevant family and custodial history, including non-familial custody and guardianship;

(iii) Client and family abuse of substances;

(iv) Medical history, including medications;

(v) History, if available, as a victim of physical abuse, sexual abuse, neglect, or other trauma;

(vi) History as a perpetrator of physical or sexual abuse.

(vii) The individual's and family's perception of his or her current need for services;

(viii) Identification of the individual's and family's strengths and resources; and

(ix) Evaluation of current mental status.

(b) A psychosocial evaluation of the client's status and needs relevant to the following areas, as applicable:

(i) Psychological functioning;

(ii) Intellectual functioning;

(iii) Educational/vocational functioning;

(iv) Social functioning;

(v) Developmental functioning;
(vi) Substance abuse;
(vii) Culture; and
(viii) Leisure and recreation.

(c) Evaluation of high risk behaviors or potential for such;

(d) A summary of information gathered in the clinical assessment process, in a clinical formulation that includes identification of underlying dynamics that contribute to identified problems and service needs.

(4) If the comprehensive assessment is completed prior to admission, it is updated at the time of admission to each certified service.

(5) Assessment processes include the following:

(a) Within 30 days of admission, an educational evaluation or current, age-appropriate Individualized Educational Plan (IEP), or documented evidence that the client is performing satisfactorily at school;

(b) When indicated by clinical severity, a psychiatric evaluation;

(c) A psychological evaluation, when specialized psychological testing is indicated;

(d) Monthly updates on mental status and current level of functioning, performed by a New Mexico licensed master's or doctoral level behavioral health practitioner.

(6)Assessment information is reviewed and updated as clinically indicated, and documented in the client's record. For clients who have been in the service for one year or longer, an annual mental status exam and psychosocial assessment are conducted and documented in the client's record as an addendum to previous assessment(s). The agency makes every effort to obtain all significant collateral information and documents its efforts to do so. As collateral information becomes available, the comprehensive assessment is amended.

E. Treatment planning and discharge planning: The treatment planning process is individualized and ongoing, and includes initial treatment planning, comprehensive treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria.

(1) For certified services other than Case Management Services and Behavior Management Skills Development Services, an initial treatment plan is developed and documented within 72 hours of admission to each service. Based on information available at the time, the initial treatment plan contains the treatment planning elements identified above in 23.E (3) (a) through (j) below, with the exception that individualized treatment goals and objectives are targeted the first 14 days of treatment.

(2) For certified services other than Case Management and Behavior Management Skills Development Services, a comprehensive treatment plan based on the comprehensive assessment is developed within 14 days of admission. The comprehensive treatment plan contains the treatment planning elements identified above in 23.E (3) (a) through (j) below.

(3)Each initial and comprehensive treatment plans fulfill the following functions:

(a) Involves the full participation of treatment team members, including the client and his or her parents/legal guardian, who are involved to the maximum extent possible; reasons for nonparticipation of client and/or family/legal guardian are documented in the client's record;

(b) Is conducted in a language the client and/or family members can understand, or is explained to the client in language that invites full participation;

(c) Is designed to improve the client's motivation and progress, and strengthen appropriate family relationships;

(d) Is designed to improve the client's self-determination and personal responsibility;

(e) Utilizes the client's strengths;

(f) Is conducted under the direction of a person who has the authority to effect change and who possesses the experience and qualifications to enable him/her to conduct treatment planning. Treatment plans meet the provisions of the Children's Code, NMSA 1978, Sections 32A-6-10, as amended, and are otherwise implemented in accordance with the provisions of Article 6 of the Children's Code;

(g) Documents in measurable terms the specific behavioral changes targeted, including potential high-risk behaviors; corresponding time-limited intermediate and long-range treatment goals and objectives; frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures; the staff responsible for each intervention; projected timetables for the attainment of each treatment goal; a statement of the nature of the specific problem(s) and needs of the client; and a statement and rationale for the plan for achieving treatment goals;

(h) Specifies and incorporates the client's permanency plan, for clients in the custody of the Department;

(i) Provides that clients with known or alleged history of sexually inappropriate behavior, sexual aggression or sexual perpetration are adequately supervised so as to ensure their safety and that of others; and (j) documents a discharge plan that:

(i) requires that the client has achieved the objectives of the treatment plan;

(ii) requires that the discharge is safe and clinically appropriate for the client;

(iii) evaluates high risk behaviors or the potential for such;

(iv) explores options for alternative or additional services that may better meet the client's needs;

(v) establishes specific criteria for discharge to a less restrictive setting; and

(vi) establishes a projected discharge date, which is updated as clinically indicated.

(4) For Residential Treatment Services and Group Home Services, the comprehensive treatment plan also includes the following elements: a statement of the least restrictive conditions necessary to achieve the purposes of treatment, and an evaluation of the client's cultural needs and provision for access to cultural practices, including culturally traditional treatment.

(5) For Case Management Services, a service plan is developed and written within 30 days of the initiation of services (see 26.F.1).

(6) For Behavior Management Skills Development Services, a service plan is developed within 14 days of initiation of services (see 28.C (1) (c).

F. The treatment plan is reviewed by the treatment team at intervals not to exceed 30 days and is revised as indicated by changes in the child's behavior or situation, the child's progress, or lack thereof.

(1)Each treatment plan review documents assessment of the following, in measurable terms:

(a)Progress, or lack thereof, toward each treatment goal and objective;

(b) Progress toward and/or identification of barriers to discharge;

(c) The client's response to all interventions, including specific behavioral interventions;

(d) The client's response to medications;

(e) Consideration of significant events, incidents, and/or safety issues occurring in the period under review;

(f) Revisions of goals, objectives, and interventions, if applicable;

(g) Any change(s) or updates in diagnosis, mental status or level of functioning;

(h) The results of any referrals and/or the need for additional consultation;

(i) The effectiveness of behavior-management techniques used in the period under review.

(2) Some or all of the required elements of a treatment planning document may be recorded in a document other than the treatment plan/review, such as a clinical review form or format provided by, or to a payor, when the following conditions are met:

(a) All required elements are performed and documented in a timely manner by qualified clinical personnel;

(b) The client's record contains evidence of participation of treatment team members in each phase of the treatment planning process.

G. When aftercare is indicated at the time of non-emergency discharge, the agency involves the client, case manager (if applicable), the parent, legal guardian, or guardian ad litem, if applicable; and assists the client, family, or guardian in arranging appointments, obtaining medication (if applicable), transportation and meeting other identified needs as documented in the treatment/discharge plan.

H. Prevention, Planning, and Processing of Emergency Discharge:

(1) (The Agency) has established policies and procedures for management of a child who is a danger to him/herself or others or presents a likelihood of serious harm to him/herself or others. The agency acts immediately to prevent such harm. At a minimum, the policies and procedures provide that the following be documented in the client's file:

(a) (The Agency) makes all appropriate efforts to manage the child's behavior prior to proposing emergency discharge;

(b) (The Agency) takes all appropriate action to protect the health and safety of other children and staff who are endangered.

(2) In the event of a proposed emergency discharge, the agency provides, at a minimum, procedural due process including written notice to the family/legal guardian, guardian ad litem and

Department, if applicable, and provision to stop the discharge action until the parent/legal guardian, guardian ad litem and/or the Department exhausts any other legal remedy they wish to pursue. The agency documents the following in the client record:

(a) Provision for participation of the parent/legal guardian, and guardian ad litem in the discharge process, whenever possible; and

(b) Arrangement for a conference to be held including all interested persons or parties to discuss the proposed discharge, whenever possible.

(3) If the child's parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the child until a safe and orderly discharge is effected. If the child's family refuses to take physical custody of the child, the agency refers the case to the Department.

I. Discharge: Non-emergency discharge occurs in accordance with the client's discharge plan, unless precipitated by a client's or guardian's refusal to consent to further treatment, or other unforeseen circumstances. Prior to discharge, the agency:

(1) Evaluates the appropriateness of release of the client to the parent/legal guardian;

(2) Provides that any discharge of the client occurs in a manner that provides for a safe and orderly transition; and

(3)Provides for adequate pre-discharge notice, including specific reason for discharge.

BEHAVIOR MANAGEMENT, PERSONAL RESTRAINT, AND SECLUSION PRACTICES:

7.20.11.24 Certain provisions of this section are included to implement regulations of the federal Centers for Medicare and Medicaid Services (CMS) and may be amended when appropriate to reflect subsequent changes in the federal CMS regulations. These provisions are intended to implement, and to be consistent with the Child Health Act of 2000 and the CMS Interim Final Rule issued May 22, 2001, and are subject to further modifications as dictated by CMS.

A.(The Agency) protects and promotes the rights of each client in the program, including the right to be free from physical or mental abuse, corporal punishment, and any personal restraint or seclusion imposed for purposes of discipline or convenience. The agency establishes and follows policies and procedures governing the use of behavior management practices including therapeutic hold, personal restraint and seclusion (when allowed as delineated below). This will include documentation of each therapeutic hold, personal restraint and seclusion in the client's record.

B. For those behavior management practices that are allowed for each type of program and are described above, the program supports their limited and justified use through:

(1) Staff orientation and education that create a culture emphasizing prevention of the need for therapeutic hold, personal restraint and seclusion and their appropriate use;

(2) Assessment processes that identify and prevent potential behavioral risk factors; and

(3) The development and promotion of preventive strategies and use of less restrictive alternatives.

C. Agency policy and procedures identify qualified staff authorized to approve the protocols and apply the criteria for use of therapeutic hold, personal restraint and seclusion.

D. Performance-improvement processes identify opportunities to reduce or eliminate the use of personal restraint or seclusion.

E.(The Agency) establishes and follows policies and procedures for the safe, effective, limited, and least restrictive use of behavior management practices. The policies and procedures include measures to ensure that treatment planning includes regular review of the necessity for, type and frequency of behavior management practices used in individual cases.

F. When behavior management practices are used, the agency protects the safety, dignity, and privacy of clients to the maximum extent possible at all times during each procedure.

G. Treatment plans document the use of seclusion, personal restraint and therapeutic holds and include: consideration of the client's medical condition(s); the role of the client's history of trauma in his/her behavioral patterns; the treatment team's solicitation and consideration of specific suggestions from the client regarding prevention of future physical interventions.

H. Seclusion, personal restraint and therapeutic holds are implemented only by staff who have been trained and certified by a State recognized body in the prevention and use of therapeutic holds, personal restraint and seclusion. This training emphasizes de-escalation techniques and alternatives to physical contact with clients as a means of managing behavior. Clients do not participate in the therapeutic holding, personal restraint or seclusion of other clients.

I .Mechanical and chemical restraints are prohibited in all programs except the program created under the Adolescent Treatment Hospital Act, which has been mandated by NMSA 1978 Sections 23-9-1 et.seq., to serve adolescents who are violent or have a history of violence, and which provides 24-hour on-site professional medical services in accordance with Section 3207 of the Children's Health Act of 2000.

J. Personal restraint and seclusion, as defined in these Certification Requirements, are used in JCAHO-accredited or non-JCAHO-accredited Residential Treatment Centers and Group Homes; in emergency circumstances to ensure the immediate physical safety of the client, other clients, staff member(s) or others; and when less restrictive interventions have been determined to be ineffective. Personal restraint and seclusion are used in accordance with these provisions and with federal law, rule or regulation which may supersede State or accreditation regulations. Personal restraint and seclusion are imposed only by an individual trained and certified by a State-recognized body in the prevention and use of personal restraint and seclusion and in the curriculum that may be set forth in federal regulations to be promulgated under Title V of the Public Health Service Act (42 U.S.C. 290aa et seq. as amended by section 3208, Part I, section 595). When federal regulations are promulgated under Title V as described above, the curriculum set forth there shall be included in the training.

K. Physical escort is allowed as a safe means of moving a client to a safe location.

L. Personal restraint or seclusion are not to be used for staff convenience and/or as coercion, discipline, or retaliation by staff.

M.This sub-section (M) applies, for personal restraint, to facilities accredited by JCAHO, and to all Residential Treatment Centers for seclusion. These entities require orders that are consistent with Department regulation, agency policy, and regulations of the Centers for Medicare and Medicaid Services (CMS) 42 CFR, Parts 441 and 483. These orders are issued by a restraint/seclusion clinician within one hour of initiation of personal restraint or seclusion, and include documented clinical justification for the use of personal restraint or seclusion.

(1) If the client has a treatment team physician and he or she is available, only he or she can order personal restraint or seclusion.

(2) If personal restraint or seclusion is ordered by someone other than the client's treatment team physician, the restraint/seclusion clinician will consult with the client's treatment team physician as soon as possible and inform him or her of the situation requiring the client to be restrained or placed in seclusion and document in the client's record the date and time the treatment team physician was consulted and the information imparted.

(3) The restraint/seclusion clinician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the situation.

(4) If the order for personal restraint is verbal, the verbal order must be received by a restraint/seclusion clinician or a New Mexico licensed registered nurse (RN) or practical nurse (LPN). The restraint/seclusion clinician must verify the verbal order in a signed, written form placed in the client's record within 24 hours after the order is issued.

(5) A restraint/seclusion clinician's order must be obtained by a restraint/seclusion clinician or New Mexico licensed RN or LPN prior to or while the personal restraint or seclusion is being initiated by staff, or immediately after the situation ends.

(6)Each order for personal restraint or seclusion must be documented in the client's record and will include:

(a) The name of the restraint/seclusion clinician ordering the personal restraint or seclusion;

(b)The date and time the order was obtained;

(c) The emergency safety intervention ordered, including the length of time;

(d) The time the emergency safety intervention actually began and ended;

(e) The time and results of any one-hour assessment(s) required; and

(f) The emergency safety situation that required the client to be restrained or put in seclusion; and

(g) The name, title, and credentials of staff involved in the emergency safety

intervention.

(7) Supervision and assessment of personal restraint or seclusion

(a) The restraint/seclusion clinician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(b)A New Mexico Registered Nurse or a restraint/seclusion clinician other than a doctoral level psychologist, must conduct a face-to-face assessment of the physical well being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. A restraint/seclusion clinician or a New Mexico Registered Nurse must conduct a face-to-face assessment of the psychological well being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, but in no case later than one hour after its initiation.

(c)If the situation requiring emergency safety intervention continues beyond the time limit of the order for the use of personal restraint or seclusion, the New Mexico RN or LPN must immediately contact the ordering restraint/seclusion clinician or the client's treatment team physician to receive further instructions. If clinical circumstances justify renewal of personal restraint or seclusion, then the renewal order must be obtained within the time frames outlined in 24.O (1) below.

N. This sub-section (N) applies to personal restraint in Residential Treatment Services not accredited by JCAHO. In these Residential Treatment Services, personal restraint requires the following, which is consistent with Department regulation and agency policy.

(1) A New Mexico Licensed Independent Practitioner, Licensed Professional Mental Health Counselor (LPC), Licensed Master Social Worker (LMSW), or Registered Nurse must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(2) A New Mexico Licensed Independent Practitioner, or a Licensed Professional Mental Health Counselor (LPC), Licensed Master Social Worker (LMSW), in consultation with a Licensed Independent Practitioner, or a Registered Nurse trained in the use of emergency safety interventions must conduct a face-to-face assessment of the well-being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, bu in no case later than one hour after its initiation.

O. The following sub-section applies to all Residential Treatment Centers and Group Homes.

(1) The personal restraint or seclusion is limited to a maximum of two hours for clients age of 17 and one hour for clients under nine years of age.

(2) Post-intervention debriefings with the client will take place after each emergency safety intervention and the staff will document in the client's record that the debriefing sessions took place.

(3) (The Agency) will have affiliations or written transfer agreements in effect with one or more
hospitals approved for participation under the Medicaid program that reasonably ensure that:

(a) A client will be transferred from the facility to the hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

(b) Medical and other information needed for care of the client in light of such transfer will be exchanged between the organizations in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

(c) Services will be available to each client 24 hours a day, seven days a week.

(4) (The Agency) will document in the client's record all client injuries that occur as a result of an emergency safety intervention.

(5) (The Agency) will attest in writing that the facility is in compliance with CMS standards governing the use of personal restraint and seclusion. This attestation will be signed by the agency director.

(6) If the client is a minor, the agency will notify the parent(s) or legal guardian(s) that personal restraint or seclusion has been ordered as soon as possible after the initiation of each emergency

safety intervention. This will be documented in the client's record, including the date and time of notification, the name of the staff person providing the notification, and who was notified.

(7) (The Agency) will provide for client health and safety by requiring direct service staff to demonstrate competencies related to the use of emergency safety interventions on a semiannual basis. Direct service staff will demonstrate, on an annual basis, their competency in the use of cardiopulmonary resuscitation. The agency will document in the staff personnel records that the training required was successfully completed.

(8) (The Agency) will maintain an aggregate record of all situations requiring emergency safety intervention, the interventions used and their outcomes.

(9) Programs must report the death of any client to the CMS regional office by no later than close of business the next business day after the client's death. The report must include the name of the client and the name, street address and telephone number of the agency. The parent or legal guardian will also be notified. Staff must document in the client's record that the death was reported to the CMS regional office.

MEDICATIONS:

7.20.11.25 A. (The Agency) has established policies and procedures governing the storage, handling, use, administration and disposal of all medications that are consistent with applicable laws, regulations, and accepted professional practices.

B. Prescription orders are verified and individuals are identified before medications are administered or self-administered.

C. Medications are administered only by qualified, licensed medical staff, or are self-administered by the client with supervision of staff who have been trained in assisting with self-administration.

D. Policies and procedures support self-administration of medications. Staff trained in these procedures provide supervision of self-administration of medications and document the time the medications are taken, the side effects observed, and client response**,** as well as any medications refused or held. When medications are self-administered by clients, a staff member may hold the container for the client and/or assist with opening the container, but may not place the medication in the client's hand or mouth.

E.(The Agency) maintains locked storage of medication and access by authorized personnel only.

F.(The Agency) has procedures in place to ensure that medications are properly labeled with name of person served, dosage, name of medication, name of prescribing physician, and number or code identifying the written order.

G.(The Agency) has secured a place for the destruction of out-of-date medications and proper disposal of unused medication and syringes.

H. When adverse or unusual conditions are observed, appropriate consultation and/or medical response must be sought in a timely manner.

I. Medication monitoring may include input from various disciplines and the client and family. This information is used to maintain and improve the outcomes of medication therapy while minimizing any drug-related problems or adverse effects.

J. When medications that require periodic testing of drug levels are used, such laboratory test results are accurately recorded in the client record, as applicable.

K. The physician documents in the client record the indication for, response to, and the potential and observed side effects of any prescription medication(s).