

TITLE 7 HEALTH
CHAPTER 20 MENTAL HEALTH
PART 11 CERTIFICATION REQUIREMENTS FOR CHILD AND ADOLESCENT MENTAL
HEALTH SERVICES

7.20.11.1 ISSUING AGENCY: Children, Youth and Families Department
[7.20.11.1 NMAC - Rp 7 NMAC 20.11.1, 03/29/02]

7.20.11.2 SCOPE: This policy applies to all child and adolescent behavioral health programs described herein.
[7.20.11.2 NMAC - Rp 7 NMAC 20.11.2, 03/29/02]

7.20.11.3 STATUTORY AUTHORITY: 1978 NMSA Sections 32A-12.1 et seq.
[7.20.11.3 NMAC - Rp 7 NMAC 20.11.3, 03/29/02]

7.20.11.4 DURATION: Permanent
[7.20.11.4 NMAC - Rp 7 NMAC 20.11.4, 03/29/02]

7.20.11.5 EFFECTIVE DATE: March 29, 2002 unless a later date is cited at the end of section.
[7.20.11.5 NMAC - Rp 7 NMAC 20.11.5, 03/29/02]

7.20.11.6 OBJECTIVES:
A. to establish certification requirements for behavioral health services provided to children and adolescents of New Mexico through the medicaid program (Title XIX of the Social Security Act);
B. to provide for monitoring of agency compliance with these certification requirements to identify any factors that could affect the health, safety, and welfare of the clients or the staff;
C. to assure that the agency establishes and follows written policies and procedures that specify how these certification requirements are met; and
D. to assure that adequate supervision is provided at all times.
[7.20.11.6 NMAC - Rp 7 NMAC 20.11.6, 03/29/02]

7.20.11.7 DEFINITIONS:
A. ABUSE means an intentional or negligent infliction of physical or psychological harm; intentional or negligent sexual contact or sexual exploitation; intentional or negligent behavior that jeopardizes life or health; torture, cruel confinement or corporal punishment.
B. ACCREDITED means written acknowledgement from a national organization that an agency or program meets the published standards of the organization issuing the accreditation.
C. ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) means a facility with 16 beds or less that may be attached to, or housed within, a hospital or other institution; that provides residential treatment services pursuant to these requirements; and that is accredited by JCAHO.
D. ACTION PLAN means a written document that may be required by the licensing and certification authority (LCA) detailing an agency's proposed actions for resolving deficiencies identified by the LCA.
E. ACTIVE STATUS means a type of certification granted to a program currently serving clients.
F. ADMINISTRATOR means the person in charge of the day-to-day operation of an agency. The administrator may also be referred to as the director or operator.
G. ADMISSIONS HOLD means a type of sanction under which a program is prohibited from admitting new clients until the LCA determines that identified deficiencies are corrected, and lifts the sanction.
H. ADVANCE DIRECTIVES means an optional component of the comprehensive service plan. An individual has the right to make decisions in advance, including behavioral health treatment decisions, through a process called advance directive. An advance directive can be used to state the individual's treatment choices, preferences or instructions regarding pre-cursor crisis strategies, or can be used to name a health care agent that is someone that will make health care decisions for the individual. This section of the comprehensive service plan provides the individual the opportunity to take part in behavioral health care decisions if at some point in the future the individual is unable. This document allows the individual to express consent or refusal to medications and other health care decisions, including use of the seclusion and restraints.

- I. AGENCY means the legally responsible organizational entity administering the facility or program(s) of specific services identified and certified pursuant to these certification requirements.
- J. ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION means the supervision and assistance given to a client in the self-administration of a drug.
- K. BEHAVIORAL HEALTH ASSESSMENT means an assessment by an integrated series of procedures conducted with an individual to provide the basis for the development of an effective, comprehensive and individualized treatment plan.
- L. BEHAVIORAL HEALTH SERVICES means services designed to meet behavioral and mental health and substance abuse needs of medicaid recipients in certified services.
- M. BEHAVIOR MANAGEMENT means the use of basic techniques, such as reinforcement, redirection and voluntary time-outs to teach clients skills for managing and improving their own behavior; and the use of verbal de-escalation, therapeutic holds, personal restraint and seclusion in order to maintain a safe and therapeutic environment and to enhance the abilities of clients and care givers to manage client behavior.
- N. BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES (BMS) means services provided on a staff-to-child ratio of at least 1:1. Behavior management skills development services are for children and adolescents with psychological, emotional, behavioral, neurobiological or substance abuse problems in the home, community or school when such problems are of such severity that highly supportive and structured therapeutic behavioral interventions are required. These services are designed to maintain the client in his/her home, community or school setting.
- O. BEHAVIOR MANAGEMENT SERVICES PLAN means a service plan used in behavior management skills development services.
- P. CANCELLATION means an LCA action nullifying a program's certification.
- Q. CAPACITY means the maximum number of clients allowed to receive services in a licensed facility at any specified time in accordance with these certifications requirements.
- R. CASE MANAGEMENT SERVICES means services provided in order to assist children and adolescents with identifying and meeting multiple and complex, special physical, cognitive and behavioral health care needs through planning, securing, monitoring, advocating and coordinating services.
- S. CARF means council on accreditation of rehabilitation facilities.
- T. CERTIFICATION means an authorized status conferred by the department on a program that meets these certification requirements for providing service(s) to children and adolescents.
- U. CERTIFIED FAMILY SPECIALISTS (CFS) means an individual 18 years of age or older who has personal experience navigating any of the child or family-serving systems or advocating for family members who have a knowledge of and are involved with the behavioral health systems and are certified by an approved state of New Mexico certification program.
- V. CERTIFIED PEER SPECIALISTS (CPS) means a self-identified current or former consumer, 18 years of age or older, of mental health or substance abuse services and has at least one year of mental health or substance abuse recovery and is certified as a CPS by an approved state of New Mexico certification program.
- W. CHEMICAL RESTRAINT means the administration of a medication(s) which is neither a standard treatment for the client's medical or psychiatric condition nor a part of the client's daily medication regimen, and is used for the primary purpose of controlling a client's behavior or restricting a client's freedom of movement.
- X. CHILD/ADOLESCENT means a person under the chronological age of 21 years.
- Y. CLEARED STAFF MEMBER means an individual who has been approved by the department for employment in the immediate presence of children and adolescents by means of a state and federal criminal background clearance.
- Z. CLIENT means any child or adolescent who receives treatment from a service certified by the department.
- AA. COA means council on accreditation for children and family services.
- AB. CLINICAL STAFF means licensed mental health practitioners and treatment coordinators.
- AC. CLINICAL SUPERVISOR means a staff member who is a licensed independent practitioner and who has responsibility and authority for supervising other clinical staff.
- AD. COMMUNITY SUPPORTS means the coordination of resources to individuals/families necessary for them to implement strategies to promote recovery, rehabilitation and resilience.
- AE. COMMUNITY SUPPORT WORKER (CSW) means the primary staff responsible for assisting the client and family with implementation of the comprehensive service plan and coordinating or facilitating family

and treatment team meetings and is certified by an approved state of New Mexico certification program.

AF. **COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS)** means a variety of interventions, primarily face-to-face and in community locations that address barriers that impede the development of skills necessary to independent functioning in the community. It provides assistance with identifying and coordinating services and supports identified in an individual's comprehensive service plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices. The target population for CCSS includes children, youth and adults with significant behavioral health disorders and who meet other criteria as identified by the collaborative.

AG. **CONTRACTOR** means an individual who provides direct services to clients through contracts with the agency.

AH. **CORPORAL PUNISHMENT** means a form of discipline or behavior control that involves forced exercise or touching a child's body with the intent to induce pain and includes, but is not limited to, shaking, spanking, hitting, hair pulling, and ear pulling.

AI. **CRIMINAL RECORDS CHECK (CRC)** means the process of submitting state and FBI approved fingerprint cards and any additional required background information to the department for the purpose of determining whether or not an individual has state or federal convictions on record that may disqualify the individual from direct unsupervised contact with children/adolescents and, when applicable, for the purpose of obtaining and reviewing a record of convictions.

AJ. **CRIMINAL RECORDS CLEARANCE** means a determination made by the department, based on the results of the criminal records check, that an individual may work directly and unsupervised with children and adolescents.

AK. **CRISIS MANAGEMENT SERVICES** means those services identified in the individual's crisis plan. Such services are located in the community, include natural supports and are available to the client and family after the agency's normal operating hours.

AL. **CRISIS PLAN** means a component of the comprehensive service plan that clearly identifies the level of intensity and severity of potential crisis events and how they will be managed after normal business hours with specific resources identified for the client, family and natural supports. The crisis plan shall include defined client, family and treatment team roles and activities.

AM. **CULTURAL COMPETENCE** means the involvement, integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs. Cultural competence is illustrated by congruent behaviors, attitudes and policies that match a client's culture to increase the quality and appropriateness of behavioral health care and outcomes.

AN. **CULTURALLY COMPETENT ASSESSMENT** means the relevant cultural considerations in the assessment of the behavioral health needs of a client.

AO. **DAY TREATMENT SERVICES (DTS)** means a coordinated and intensive set of structured individualized therapeutic services, in a school, or a facility licensed by the LCA, provided for children, adolescents and their families who are living in the community.

AP. **DEFICIENCY** means a violation of, or failure to comply with, a provision(s) of these certification requirements.

AQ. **DENIAL** means a sanction imposed by the LCA to refuse to issue a certification, based on a determination made by the LCA.

AR. **DEPARTMENT** means the New Mexico children, youth and families department.

AS. **DESIGNATED AGENCY** means the agency that has the primary responsibility of partnering with the client and family for implementation of the comprehensive service plan.

AT. **DIRECT PHYSICAL SUPERVISION** means, with reference to criminal records clearances, either continuous visual observation or live video observation of a non-cleared agency staff member by a cleared agency staff member or by the client's legal guardian, while the non-cleared staff is in immediate presence of the client.

AU. **DIRECT SERVICE STAFF** means supervisors, physicians, nurses, therapists, client care workers, coordinators or other agency personnel who work in immediate direct unsupervised contact with children.

AV. **DIRECT UNSUPERVISED CONTACT** means physical proximity to clients, such that physical contact or abuse could occur, without being observed or noticed by another staff member who has been cleared by the department.

AW. DIRECTED ACTION means a formal action(s) specified by the LCA that the agency is required to undertake or complete in order to correct a deficiency(ies) within a specified time frame.

AX. DISCHARGE CRITERIA means specific clinically-based indicator(s) used to measure the client's degree of readiness for release from a given level of care stated in terms of achievement of treatment goals or reduction of symptoms; discharge criteria may also include indicators that a given level of care is inappropriate for a client due to such factors as dangerousness or non-responsiveness to treatment.

AY. DISCHARGE PLAN means a written section of a treatment plan/service plan and treatment plan/service plan reviews containing the following elements: behavioral and other clinical criteria that describe the conditions under which discharge will occur, identification of barriers to discharge; the level of care, specific services to be delivered, and the living situation into which discharge is projected to occur; the projected date of discharge, individuals responsible for implementing each action specified in the discharge plan, and, when indicated, revisions.

AZ. DISCIPLINE means non-abusive training that enables a client to develop self-control and orderly conduct in relationship to others.

BA. DOCUMENTATION means the written or printed record of information supporting the facts related to the certified services being provided to clients found in client files, personnel files, and other pertinent printed sources.

BB. EARLY AND PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means periodic, comprehensive services to persons under 21 years of age; these services are defined in the medicaid program policies.

BC. EMERGENCY SAFETY INTERVENTION means personal restraint or seclusion.

BD. EMERGENCY SANCTION means an immediate requirement that is imposed on a program by the LCA in response to a finding of health or safety deficiency(ies).

BE. EMERGENCY SERVICE means an unanticipated admission to an acute medical or psychiatric facility or the provision of other medical services by paramedics or other emergency or urgent care personnel.

BF. EMERGENCY SUSPENSION means an immediate and temporary cancellation of a certification due to an existing health or safety deficiency(ies), pending an appeal hearing and correction of health or safety deficiencies. During a period of emergency suspension, the medicaid provider agreement is not in effect.

BG. EMPLOYMENT HISTORY means a verifiable written summary of employment including names, addresses 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 immediately prior to hire for employment by a certified program.

BH. ENHANCED SERVICE means, in the medicaid managed care system, any and all services beyond the scope of the medicaid (fee-for-service) benefit package available to recipients in the medicaid managed care program.

BI. EXCLUSIONARY CRITERIA means agency-written criteria that define the diagnoses, behaviors, or conditions that preclude admission to the certified program.

BJ. EXEMPLARY means a certified status conferred by the LCA on a program that has no history of temporary certification, sanctions or loss of certification in the previous two years and meets all of the certification requirements with minor or no deficiencies.

BK. EXPANSION HOLD means a type of sanction under which an agency is prohibited from obtaining certification for additional services until the LCA determines that identified deficiencies are corrected and lifts the sanction.

BL. EXPLOITATION means the act or process of using a client or client's property for another person's profit, advantage or benefit.

BM. FACILITY means the physical plant and building(s) licensed by the LCA in which residential or day treatment mental health services are provided.

BN. FUNCTIONAL LEVEL means a determination of the client and as applicable, his family's, functional skills in multiple domains.

BO. GENERAL PROVISIONS means the series of certification requirements found in Sections 9 through 25 of these certification requirements.

BP. GOVERNING BODY means the organizational entity of an agency that has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a program certified pursuant to these certification requirements.

BQ. GROUP HOME SERVICES (GHS) means mental and behavioral health services offered in a

supervised, licensed facility that provides structured therapeutic group living for children/adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, when clinical history and opinion establish that the needs of the client cannot be met in a less restrictive environment.

BR. HEALTH OR SAFETY DEFICIENCY means a deficiency that poses an immediate threat to the welfare of clients up to and including loss of life; physical harm; physical, sexual, psychological abuse or exploitation.

BS. HUMAN SERVICES DEGREE means an approved bachelors or masters degree from an accredited school in one of the following degrees: counseling and therapy, rehabilitation, psychology, criminal justice, social work/social services, or human development. If workforce issues are identified in a region of the state, the some other defined degrees may be considered as human services degrees. However, any experience required in the service definition must be met. In order for an agency to utilize staff with these degrees, they must submit a written waiver request to LCA with documentation supporting the workforce issues. Those alternative degrees may include nursing, sociology, public health, education, occupational therapy, speech and hearing sciences, speech-language pathology, communication sciences and disorders, gerontology, or social sciences.

BT. INACTIVE STATUS means a type of certification granted to a program that is not currently serving clients.

BU. INCIDENT REPORT means the document(s) describing a serious incident or alleged serious incident.

BV. INFORMAL RESOLUTION CONFERENCE means an informal meeting and problem-solving process between the department and an agency to resolve any filed or potential appeal arising from the imposition or potential imposition of a sanction(s).

BW. INFORMED CONSENT means a document that reflects that a client and the legal guardian(s) are advised of the benefits, risks, and alternatives of a given medication or treatment and agree to the use of the medication or treatment. Clients age 14 and above may consent to the use of a medication or treatment without the approval of their legal guardian(s).

BX. INITIAL CERTIFICATION means a type of certification granted to a program that has met the minimum requirements to implement a program to provide services pursuant to these requirements.

BY. INVESTIGATION means a formal process of inquiry used by the LCA to: determine the validity of complaints or allegations made against certified agencies; or to determine whether trends in incidents reported to the LCA that affect the health and safety of clients are the result of negligent practices, insufficient supervision of personnel or clients, or any other factor that requires correction; or to determine whether or not an agency has made corrective responses to resolve matters of threat to client health and safety substantiated by the LCA.

BZ. JCAHO means the joint commission on accreditation of healthcare organizations.

CA. LICENSE means the written authorization issued by the LCA pursuant to 7.20.12 NMAC granting right to operate the designated facility for a specified period of time; or, in context, any necessary authorization by the appropriate credentialing authority to undertake the professional activity in question.

CB. LICENSED INDEPENDENT PRACTITIONER means New Mexico-licensed clinical staff who are authorized to practice at the independent level.

CC. LICENSED INDEPENDENT MEDICAL PRACTITIONER means a New Mexico licensed medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), clinical nurse specialist (LCNS), or physician assistant (PA).

CD. LICENSING AND CERTIFICATION AUTHORITY (LCA) means the licensing and certification unit of the children's behavioral health and community services bureau of the prevention and intervention division of the department.

CE. MAINTENANCE OR REDUCTION IN PROGRAM CAPACITY means a sanction that directs the agency to maintain or reduce the capacity of the program to a designated census until the LCA determines that deficiencies resulting in the sanction have been corrected.

CF. MECHANICAL RESTRAINT means use of a mechanical device(s) to physically restrict a client's freedom of movement, performance of physical activity, or normal access to his or her body, and is distinct from personal restraint as defined below.

CG. MEDICAID means Title XIX of the Social Security Act; the joint federal-state program that pays for medical care for low-income persons.

CH. MONITORING means the ongoing review of a program's progress in correcting deficiencies. During a period of certification, monitoring is done at the discretion of the LCA. Monitoring may be implemented by means of a monitoring plan, and may require that specified documentation be submitted to the LCA by the

agency or may include the use of on-site surveys by the LCA to ascertain compliance in specified areas.

CI. MONITORING PLAN means a written set of guidelines and instructions specified by the LCA for a program to follow for the purpose of correcting deficiencies.

CJ. MORAL TURPITUDE means conduct contrary to justice, honesty, modesty or good morals, as further specified in 8.8.3 NMAC.

CK. MULTISYSTEMIC THERAPY (MST) is an intensive family and community-based treatment program that addresses the known determinants of serious antisocial behavior in adolescents and their families. MST treats the factors in the youth's environment that are contributing to his or her behavior problems. Such factors might pertain to individual characteristics of the youth (poor problem solving skills), family relations (inept discipline), peer relations (association with deviant peers) and school performance. Treatment goals for therapeutic change are developed on an individualized basis in collaboration with the family.

CL. NEGLECT by individuals or an agency means:

(1) failure to provide any treatment, service, care, medication or item that is reasonably necessary to maintain the health or safety of a client; or

(2) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a client; or

(3) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good service or medication reasonably necessary to maintain the health or safety of a client; or

(4) failure to take any reasonable precaution that would prevent the physical abuse, sexual abuse, or sexual exploitation of a client, as defined in the Children's Code at 1978 NMSA 32A-4-2, or the lack of which causes the client to become an abused child or neglected child as defined in the Children's Code at NMSA 1978 32A-4-2.

CM. NON-ACCREDITED RTC means a program that provides residential treatment services pursuant to these requirements that is not accredited by JCAHO.

CN. NON-RENEWAL means a sanction whereby certification is cancelled on or about the date of expiration.

CO. NON-RESIDENTIAL SERVICES means a program that provides certified services other than twenty-four-hour continuous care within the confines of a facility or treatment foster home.

CP. NOTICE OF CONTEMPLATED ACTION means a letter issued by the LCA identifying grounds for sanction of a program.

CQ. NOTICE OF EMERGENCY SANCTION means a letter issued by the LCA when an emergency sanction is imposed.

CR. NOTICE OF FINAL ACTION means a letter issued by the LCA stating that the sanctions proposed in a previous notice of contemplated action are in effect. This letter is issued upon the conclusion of any appeal/informal resolution proceeding or the expiration of the appeal period to the notice of contemplated action.

CS. PARTIAL COMPLIANCE means a determination by the LCA that a program is found to have moderate and few deficiencies, none of which immediately compromises the health or safety of the clients.

CT. PARTIALLY SUBSTANTIATED COMPLAINT means a complaint that the LCA has determined is factually accurate in part, but not factually accurate in its entirety.

CU. PERMANENCY PLAN means the long-term plan for the child/adolescent developed by the protective services division of the department with one of the following outcomes: reunification, permanent guardianship, adoption, permanent placement with a fit and willing relative, or planned permanent living arrangements.

CV. PERSONAL RESTRAINT means the application of physical force without the use of any device, for the purposes of restraining the free movement of a client's body. The term personal restraint is distinct from therapeutic hold and mechanical restraint as defined herein and does not include briefly holding a client, without undue force, in order to calm or comfort him or her, or holding a client's hand to safely escort a client from one area to another.

CW. PHYSICAL ESCORT means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purposes of inducing a client who is exhibiting unsafe or potentially unsafe behavior to walk to a safe location.

CX. PHYSICAL HARM means physical injury that requires treatment beyond basic first aid; or that results in loss of functional use of a bodily member or organ or of a major life activity for a prolonged period of time; or results in loss of consciousness for any amount of time.

CY. PHYSICIAN means an individual who has received a degree of doctor of medicine or doctor of

osteopathic medicine and is licensed to practice medicine in the state of New Mexico.

CZ. POLICY means a statement of principle that guides and determines present and future decisions and actions.

DA. PREMISES means all parts of buildings, grounds, vehicles and equipment of a facility.

DB. PRE-SERVICE TRAINING means training that is provided to a newly hired employee prior to the employee's provision of direct services.

DC. PROCEDURE means the action(s) that will be taken to implement a policy; and the written description of such action(s) that serves as instruction to agency staff.

DD. PROGRAM means an agency, or subdivision of an agency, operated with the intent to provide certified services.

DE. PROVIDER means an agency or its personnel who have a medicaid provider number and deliver direct services to clients.

DF. PSYCHIATRIST means a physician who specializes in the treatment of psychiatric disorders, has completed an accredited psychiatric residency program, and holds a current license to practice medicine in the state of New Mexico.

DG. PSYCHOLOGICAL HARM means harm that causes symptoms of mental or emotional trauma, or that causes distress of sufficient magnitude to cause behavioral change, or physical symptoms that may require psychological or psychiatric evaluation or treatment.

DH. PSYCHOLOGIST means a doctoral level psychologist who specializes in assessing and treating psychological disorders and holds a current license to practice in the state of New Mexico.

DI. PUNISHMENT means a penalty imposed on a child/adolescent by one in authority for wrongdoing.

DJ. RECOVERY means the process, outlook, vision and guiding principle that stresses that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society (adapted from *Mental Health: A Report to the Surgeon General, Chapter 2, 1999*).

DK. RECOVERY/RESILIENCY MANAGEMENT PLAN means the foundational component for building the comprehensive service plan. The recovery/resiliency management plan component focuses on strengths and preferences based on identified competencies, the process of autonomy (independence), and developing a system of natural supports (satisfying and supportive social relationships). The recovery/resiliency management plan component shall include:

- (1) the client and family's personal choice of service options and priorities in service delivery with a client centered focus;
- (2) client driven interventions including attainable objective to address the client's defined needs;
- (3) a clear identification of the environment in which the client lives including: family, school peers, community and home, and how each will play a part in the comprehensive service plan; and
- (4) a clear approach to the development of resiliency based on life skills identified by the client and service team.

DL. REFERENCE CHECK means a documented contact with previous employers, supervisors, co-workers, or other sources, initiated by the agency to evaluate a prospective employee prior to hire by establishing the accuracy of his/her employment history and to obtain other information relevant to potential hire.

DM. REHABILITATION means a process that enhances the efficacy of clients with functional limitations due to behavioral health disorders to obtain information, develop skills and access resources needed to make decisions and implement strategies to be successful and satisfied in the living, working, learning, and social environments of their choice. Rehabilitation services are driven by the client's desire for recovery and resiliency based outcomes and are individualized, collaborative and person directed.

DN. RESIDENTIAL FACILITY means a facility licensed by the LCA, in which 24-hour continuous therapeutic care is provided to a group of children/adolescents in accordance with these certification requirements.

DO. RESIDENTIAL TREATMENT SERVICES means a program that provides 24-hour therapeutic care to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in a residential facility.

DP. RESTRAINT/SECLUSION CLINICIAN means a New Mexico licensed medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), clinical nurse specialist (LCNS), physician assistant (PA) or doctoral level psychologist (Psy.D., Ph.D., or Ed.D.), who is trained in the use of emergency safety

interventions.

DQ. REVOCATION means a type of sanction making a certification null and void through its cancellation.

DR. SANCTION means a measure imposed by the LCA on a certified program, pursuant to these certification requirements, in response to findings(s) of a deficiency(ies), with the intent of obtaining increased compliance with these certification requirements.

DS. SECLUSION means a behavior management technique that involves locked isolation. Seclusion is distinct from therapeutic time-out.

DT. SERIOUS INCIDENT means an incident involving the death of a client, suicide attempt by a client; psychological or physical harm to a client; serious homicidal threat to or by a client; physical or sexual abuse/perpetration to, or by, a client or a staff member; the use, possession, or distribution of illegal substances by clients or staff; neglect or exploitation of a client by staff; AMA or emergency discharge; arrest or detention of a client; natural disasters, or contagious disease outbreaks; or agency knowledge that a staff member has been charged with, or convicted of, a felony or of a misdemeanor involving moral turpitude, including but not limited to convictions referenced in 8.8.3 NMAC.

DU. SEXUAL ABUSE means any intentional and uninvited contact, demand or enticement of a sexual nature, including contact with another person's clothed or unclothed genital area, anus, buttocks, or breast(s) if the recipient is female; or, intentional causing of another person to touch any of these areas on one's own or a third party's body; or, consensual contact with any of these areas if the initiator is in a position of significant influence over the recipient by reason of differences in age, physical size, development, intellectual sophistication, sexual sophistication, or position of authority; or, a verbal request, offer, or demand such as would initiate such contact when the initiator of the verbal behavior is in a position of significant influence as described above. Physical contact, as described above, includes contact between clothed or unclothed body parts of individuals, or may be between clothed or unclothed body parts of one person and an object.

DV. STAFF means a person who has contact with children in a certified program and includes the owner, operator or director of a program, volunteers, full-time, part-time, contract employees, and treatment foster parents.

DW. STAY means the department is temporarily refraining from taking an action on a sanction, revocation, or suspension of certification.

DX. SUBSTANTIAL COMPLIANCE means a determination by the LCA that a program is found to be without deficiencies, or with minor and few deficiencies, none of which compromise the health and safety of clients.

DY. SUBSTANTIATED COMPLAINT means a complaint or allegation that the LCA has determined is factual.

DZ. SUPERVISION means one of the following, as indicated by context: the monitoring of clients' whereabouts and activities by the program staff in order to ensure their health, safety, and welfare; or the clinical or managerial oversight of staff.

EA. SURVEY means examination, or other review, of a program's premises, records or other documents; or interview of client(s) or staff, at the discretion of the LCA, pursuant to these certification requirements.

EB. SUSPENSION means a type of sanction whereby certification is temporarily revoked, during which time the medicaid provider agreement is not in effect.

EC. THERAPEUTIC HOLD means the brief physical holding of a client, without undue force, used as part of a behavioral plan by an individual trained and certified by a state recognized body in the use of therapeutic holds and personal restraints, in a manner consistent with written agency policy, for the purpose of providing emotional comfort or calming to the client, or physical safety to the client, other clients, staff member(s) or others. Therapeutic hold is distinct from personal restraint and mechanical restraint as defined above.

ED. THERAPEUTIC LEAVE means a period of time during which a treatment foster care services client is temporarily placed in a different treatment foster home. This affords the primary treatment foster parents a period of authorized leave.

EE. THERAPEUTIC TIME-OUT means a technique involving individual isolation used as part of a written behavioral plan to prevent or decrease the potential for unsafe behavior and to give the client the opportunity to regain control.

EF. THERAPIST means a person who has a license from an appropriate licensing authority to provide direct clinical care services such as individual, family, or group therapy.

EG. TREATMENT FOSTER CARE SERVICES (TFC) LEVEL I means a program that provides therapeutic services to children or adolescents who are psychologically or emotionally disturbed, or behaviorally disordered, in a foster family setting, pursuant to these certification requirements.

EH. TREATMENT FOSTER CARE SERVICES LEVEL II means a program that provides therapeutic services to children or adolescents who are psychologically or emotionally disturbed, or behaviorally disordered, in a foster family setting, pursuant to these certification requirements. It is distinct from treatment foster care services level I in that it is provided to children and adolescents who have successfully completed treatment foster care services level I as determined by the treatment team, and are in the process of returning to biological family and community, or who meet other established criteria.

EI. TREATMENT FOSTER HOME means a licensed residence overseen by a certified program and licensed child placement agency in which treatment foster care services are being provided to agency clients by licensed treatment foster parents.

EJ. TREATMENT PLAN means a written document formulated on an ongoing basis by a treatment team that guides and records for each client: individualized therapeutic goals and objectives; individualized therapeutic services provided; individualized discharge plans and aftercare plans.

EK. TREATMENT PLANNING means an ongoing process, based on assessment and regular reassessment of a client's needs, of documenting those needs, the interventions intended to address those needs, and the client's behavioral responses to interventions. Treatment planning includes initial treatment plans, comprehensive treatment plans, treatment plan reviews and discharge plans.

EL. TREATMENT TEAM means the group of individuals that assesses, plans, coordinates, implements, evaluates, reviews, and adjusts all aspects of a client's care over the course of treatment in a certified program. The treatment team includes the client, and as applicable, the client's family or legal guardian(s), therapist, direct service staff, treatment coordinators, treatment foster parents, the department's social worker or juvenile probation/parole officer, case manager, a representative from an educational agency, or other significant individuals in the client's life.

EM. UNSUBSTANTIATED COMPLAINT means a complaint or allegation that could not be verified by the LCA based on its investigation.

EN. VARIANCE means a deviation from a portion(s) of these certification requirements approved in writing at the sole discretion of the LCA. It is based upon stipulated conditions to be met by the agency, for an unlimited time period, provided that the health, safety, and welfare of the clients and staff are not in danger.

EO. VOLUNTEER means an individual who works without compensation at an agency in the physical presence or proximity of clients.

EP. WRAPAROUND means a team-based activity that helps groups of people involved in a family's life work together toward a common goal.

EQ. WAIVE/WAIVER means a deviation(s) from any part of these certification requirements approved in writing by the LCA, at the sole discretion of the LCA. It is based on stipulated conditions to be met by the agency, for a limited period of time, provided the health, safety, and welfare of clients and staff is not in danger. [7.20.11.7 NMAC - Rp 7 NMAC 20.11.7, 03/29/02; A, 04/14/05; A, 01/01/08; A, 12/31/08]

7.20.11.8 RELATED REGULATIONS, LAWS AND CODES: These certification requirements supplement and apply in conjunction with the following regulations laws and codes and any future amendments to such regulations or superseding regulations.

- A. Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC.
- B. Health Facility Sanctions and Civil Monetary Penalties, 7 NMAC 1.8 (1996).
- C. New Mexico Children's Code NMSA 1978 32A-1-1 et Seq. (1997).

[7.20.11.8 NMAC - Rp 7 NMAC 20.11.8, 03/29/02]

7.20.11.9 ISSUANCE OF CERTIFICATION:

- A. Application for initial certification:

(1) Applications for the initial certification of a new program offering case management services, behavior management skills development services, day treatment services, group home services, all residential treatment services, or treatment foster care services are submitted to the LCA for review and approval. The application for initial certification of a program includes, but is not limited to, the following:

(a) a letter of intent naming the service for which the agency is requesting initial certification and describing how and where the proposed service will be delivered.

(b) policies and procedures showing that the agency complies with both the general provisions and the service-specific requirements of the program for which the agency is requesting initial certification; and an index that references each policy and procedure by the applicable certification requirement that the policy is designed to meet.

(c) job descriptions, required qualifications, resumes, current licenses, proof of credentials, and criminal records clearances for professional staff;

(d) job descriptions, required qualifications and criminal records clearances for direct service staff; and

(e) a complete set of the forms that will be used to document the services being provided.

(2) At the discretion of the LCA, the application process may include interviews with staff, administrators, or program directors.

(3) When applicant agencies have an established in-state or out-of-state history of providing mental health or substance abuse services for children and adolescents, whether or not the agency is currently providing such services, the agency's record with regulatory compliance will be considered during review of the new application;

(4) Applications will be reviewed by the LCA within 15 business days and a written response will be sent to the agency. The findings of the review will determine which of the following responses will be issued by the LCA:

(a) Complete applications that comply with all the requirements of these certification requirements will be issued an initial certification for a period of up to 120 days.

(b) Incomplete applications will be returned with a letter detailing what elements of the application are missing. initial certification will not be issued.

(c) When an application is complete, but fails to show that the agency has fully or substantially complied with all of these certification requirements, the LCA will issue a letter detailing the findings of the review, with a list of the changes required to show the new program to be in compliance with these certification requirements. An initial certification will not be issued.

(5) If, three months subsequent to the issuance of an LCA letter detailing missing or insufficient elements of an application, the agency has not responded with a completed application or has not achieved compliance with these certification requirements sufficient to warrant initial certification, the application will be considered void. The agency may reapply for certification of the service, but will be required to begin a new application process.

(6) COA/CARF/JCAHO Accreditation does not confer state certification status on a program.

B. Types of certification:

(1) **FULL CERTIFICATION:** Full certification is granted to a program currently serving clients and found by the LCA to be in substantial compliance with these certification requirements. At the discretion of the LCA, the duration of full certification status is 12 to 24 months.

(2) **EXEMPLARY STATUS** is a type of full certification that may be granted to a program that has no history of temporary certification, sanctions or loss of certification in the previous two years and that, based on a determination made by the LCA, adheres to these certification requirements with only minor deficiencies, which pose no health and safety risks to clients. Exemplary status may be granted for up to 24 months.

(3) **FULL CERTIFICATION:** This certification is granted to a program currently serving clients and found to be in substantial compliance with these certification requirements, when only minor and few deficiencies, none of which compromise client health and safety, are identified in the LCA certification report. The program submits an action plan for the LCA's approval within the time frame specified by the LCA, detailing the measures that will be used to correct the deficiencies. At the discretion of the LCA, the program may also be required to implement a directed action(s) within specified time frames; or may be required to comply with monitoring as specified by the LCA during the period of certification. Based on a determination made by the LCA, the program produces proof of correction of deficiencies and/or compliance with directed action(s) and/or monitoring through submission of relevant documentation and/or by subsequent on-site review. The terms and the timeframes for monitoring are established in writing in the certification report.

(a) The LCA provides written notification indicating whether the program's action plan is approved. Action plans may be approved with amendments recommended and/or required within a time frame specified by the LCA. If an action plan is not approved, the LCA will specify items that require revision or supplementation in order to receive LCA approval.

(b) If another survey reveals additional deficiencies, the LCA may require amendment of the

action plan, and/or issue new written directed actions, and/or implement a revised monitoring plan, and/or sanction the program based on new deficiencies identified.

(4) **TEMPORARY CERTIFICATION:** Temporary certification is granted to a program currently serving clients that is found by the LCA to be in partial compliance with the certification requirements, or to a program that has been on inactive status and is returning to active status.

(a) The LCA determines the duration of a temporary certification. Temporary certification may be granted for a period of up to 180 days. The LCA determines the duration of temporary certification based on factors that may include severity of deficiencies and the program's history of compliance with certification requirements.

(b) The program submits an action plan for the LCA's approval within 14 days of receipt of the LCA certification report detailing its findings of deficiencies, unless otherwise specified by the LCA. At the discretion of the LCA, the program may also be required to implement directed action(s) within specified time frames. The program may be required to comply with terms of monitoring specified by the LCA during the period of temporary certification, based on a determination made by the LCA.

(c) Items 9.B(3)(a) and (b) above are applicable for action plans that accompany temporary certification.

(d) For programs returning to active status, an action plan, directed action, and/or monitoring are not required unless specified by the LCA.

(e) If the program does not achieve substantial compliance with these certification requirements at the end of a temporary certification period, a sanction(s) may be imposed including non-renewal of certification.

(f) At the discretion of the LCA, a second consecutive temporary certificate may be issued for a period of up to 180 days, or certification may be allowed to expire without renewal.

(5) **INITIAL CERTIFICATION:** This certification is granted for a period of 120 days to a program that has met the minimum requirements to provide child and adolescent mental health or substance abuse services as determined by the application process described in certification requirement 9.A above. If the program has no clients at the end of 120 days, a second 120-day initial certification may be granted. If the program remains without clients beyond 240 days, the program's initial certificate expires and re-application for certification is required; or, at the discretion of the LCA, inactive status may be granted.

(6) **INACTIVE STATUS:** This certification is granted to a program not presently serving clients, but which has served clients within the current period of certification. A certificate of inactive status covers a period of time not to exceed 180 days from the date of issue. If the program continues without clients beyond 180 days, a second 180-Day certificate of inactive status may be granted upon request. If the program remains without clients beyond 365 days, the program's inactive status expires and re-application for initial certification is required.

(a) To return to active status from inactive status for a certified service, the program must notify the LCA in writing at least two weeks prior to its intended admission of clients. In addition to the written notice, the agency must submit the following to the LCA: information on any changes in personnel or agency policies and procedures during inactive status; proof of criminal records clearances, qualifications, and, as applicable, licensure for new supervisory and direct service staff of the certified program.

(b) Upon review of the submitted information, the LCA may grant temporary certification. The agency will not admit any client(s) until the LCA issues and the program receives temporary certification.

(7) **AMENDED CERTIFICATE:** This certification is granted to a program currently serving clients that has had a change of ownership or licensee, or that chooses to change its name. The agency submits a written request for an amended certificate to the LCA ten business days prior to the change.

(8) **DEEMED CERTIFICATION:** The LCA has discretion to grant deemed certification when a program is accredited by the council on accreditation (COA), the council on accreditation of rehabilitation facilities (CARF), or for residential treatment services, by the joint commission on accreditation of health care organizations (JCAHO), and the LCA determines that the standards of the accrediting body apply substantially to the program for which deemed certification is being considered. A certified program that is accredited by one of these organizations and wishes to request deemed certification must provide a copy of the accreditation report to the LCA within 30 days of receipt of the report, and must provide any other accreditation-related documentation to the LCA upon request. Upon receipt and review of the COA, CARF or JCAHO survey reports, the LCA, at its discretion, may issue deemed certification status effective for up to 24 months. For those intervening years that the above-mentioned accrediting bodies do not conduct on-site visits, the LCA may conduct annual or biennial certification on-site surveys.

(a) **EXCEPTION:** The deemed certification may not apply when COA, CARF or JCAHO identify any condition that the LCA, at its sole discretion, determines to be a significant violation of certification or accreditation standards, or that requires follow-up by the accrediting body; or when any condition reported to the LCA appears to pose a threat to health and/or safety; or when there is any other information indicating the existence of such a threat.

(b) All agencies and programs that receive deemed certification must comply with all applicable provisions of the Children's Health Act of 2000 and these certification requirements.

C. AUTOMATIC EXPIRATIONS OF A CERTIFICATION:

(1) A certificate automatically expires at midnight on the day a certified program discontinues or suspends operation or changes location.

(2) A certificate automatically expires at midnight on the tenth day after a certified program is sold, leased, or otherwise changes ownership and/or licensee, unless the agency has made a timely written request for amended certification. In such a case, the automatic expiration is stayed, and previous certification remains in effect if the agency has until the LCA acts on the application or takes other certification action.

D. WAIVERS AND/OR VARIANCES: Upon written request of the agency and at the discretion of the LCA, the LCA may issue a waiver and/or variance

E. CERTIFICATION REVIEWS: When possible, the LCA schedules on-site program reviews prior to expiration of certification. If the LCA does not perform a certification on-site review of a program prior to the expiration of its certification, and the program has not received a written report from the LCA recommending that the program's certification be allowed to expire, the certification continues in effect until the LCA performs a certification review.

F. The LCA, at its sole discretion, may extend any certification for a period of up to 12 months.

G. In the event that a program's certification is revoked, suspended, denied, or not renewed, the medicaid provider agreement terminates on the date of the revocation, suspension or denial.

[7.20.11.9 NMAC - Rp 7 NMAC 20.11.9, 03/29/02; A, 04/14/05]

7.20.11.10 EMERGENCY REVOCATION, SUSPENSION, NON-RENEWAL OF CERTIFICATION OR IMPOSITION OF EMERGENCY SANCTIONS, WITHOUT PRIOR HEARING: If immediate action is required to protect human health and/or safety, the LCA may immediately revoke, suspend, not renew, or impose an emergency sanction(s) against the certification status of a program pending a hearing, provided that such hearing is held within five business days of the above-mentioned action and/or sanction(s), unless the program waives its right to a hearing. The medicaid provider agreement terminates on the date of the revocation, suspension, or non-renewal of certification.

[7.20.11.10 NMAC - Rp 7 NMAC 20.11.10, 03/29/02]

7.20.11.11 GROUNDS FOR IMPOSITION OF SANCTIONS: Sanctions may be imposed by the LCA based on its specific findings, including but not limited to any of the following:

A. failure to comply with any provision(s) of these certification requirements;

B. failure to allow surveys by authorized representatives of the LCA; employment of any person convicted of a felony or misdemeanor without clearance by the department, including a misdemeanor involving moral turpitude;

C. allowing any agency personnel to work under the influence of alcohol or mood-altering drugs (if after employment, a staff member is charged and/or convicted of a felony or misdemeanor involving moral turpitude and this fact is known to the agency, it must be immediately reported to the LCA);

D. purposeful, deliberate or intentional misrepresentation(s) or falsification(s) of any information on application forms or other documents provided to the LCA;

E. repeated violations of these certification requirements, or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous certification periods;

F. presence of, and/or a history of, certification/licensure revocation, suspension, non-renewal, or denial of certification, sanction(s) or penalties or other similar disciplinary actions taken by regulatory bodies in other states or countries and/or within New Mexico regardless of whether any of these actions resulted in a settlement in lieu of a sanction;

G. failure to provide a client in the program with care, supervision and services or to protect client rights as outlined in these certification requirements;

H. any neglect as defined in these certification requirements;

- I. presence of, and/or a history of health and/or safety deficiencies found in current or previous surveys or on-site visits;
 - J. death or serious injury to a client;
 - K. psychological harm or cruelty and indifference to the welfare of a client;
 - L. incidents that include acts of physical harm to a client(s) by staff;
 - M. regulatory deficiencies that jeopardize the health and/or safety of a client;
 - N. numerous deficiencies, that in combination, jeopardize the health and/or safety of a client; or
 - O. non-disclosure and/or deceit regarding condition of a facility/program or the services it provides.
- [7.20.11.11 NMAC - Rp 7 NMAC 20.11.11, 03/29/02]

7.20.11.12 SANCTIONS:

A. Sanctions, as follows, may be imposed for the reasons listed in Section 11. The severity of the action taken by the department depends upon the specific facts in each case, the seriousness and history of the events prompting the department to take action, and the ability and willingness of the agency to promptly take adequate corrective action.

(1) **REVOCATION:** The LCA cancels certification, making it void. The medicaid provider agreement terminates on the date of revocation.

(2) **SUSPENSION:** The LCA temporarily revokes certification until the identified deficiencies are corrected and the LCA approves the corrections. The medicaid provider agreement terminates on the date of suspension.

(3) **NON-RENEWAL:** The LCA refuses to renew certification and issues a notice stating that the certification is void as of a specific date, on or about the date of expiration. The medicaid provider agreement terminates on the effective date of non-renewal.

(4) **DENIAL:** The LCA refuses to issue certification.

(5) **ADMISSIONS HOLD:** The LCA restricts the program from accepting any new clients until the identified deficiencies are corrected and the LCA approves the corrections.

(6) **EXPANSION HOLD:** The LCA restricts the program from expanding into additional services until the identified deficiencies are corrected and the LCA approves the corrections.

(7) **MAINTENANCE OR REDUCTION IN PROGRAM CAPACITY:** The LCA directs the program to maintain or reduce the capacity of the program to a designated client census until the LCA determines that all of the deficiencies resulting in the sanction have been corrected.

(8) **COMPLIANCE MONITOR:** The LCA may select and assign a compliance monitor and assign it to an agency for a specified period of time to oversee an agency's compliance efforts. The compliance monitor has the authority to review all applicable facility records, including financial records and policies, and the authority to interview facility staff and clients. The compliance monitor may also advise the program regarding steps to correct violations and improve overall clinical programming. The compliance monitor reports to the LCA on a weekly basis or more often when indicated. The agency pays all costs of the compliance monitor.

(9) **TEMPORARY MANAGEMENT:** The LCA appoints temporary professional management with expertise in the field of the child and adolescent mental health and/or substance abuse services provided by the program. The temporary management assumes primary responsibility to oversee the operation of the program; to protect the health and safety of its clients; to assess and direct the correction of deficiencies; and/or to facilitate an orderly closure. The temporary management reports to the LCA. The agency pays all costs of temporary management.

B. **EXTENUATING CIRCUMSTANCES:** In assessing the appropriateness or severity of sanctions, the LCA may consider any relevant factor(s) that may mitigate or exacerbate the situation precipitating the sanction.

C. **CORRECTION OF DEFICIENCIES:** When the LCA determines that deficiencies exist, the program must correct the deficiencies according to the following time frames or further sanctions may be imposed:

(1) Health and/or safety deficiencies are corrected immediately.

(2) Deficiencies that do not compromise health and/or safety are corrected within a period of time specified by the LCA.

D. **SERVICE OF NOTICE:** The department provides notification, by fax and certified mail or personal service/delivery, of its imposition of any emergency sanction against a program. A notice of contemplated action under these certification requirements may be sent by fax and mail, personal service or delivery, or by certified mail. Each notice of emergency sanction or contemplated action will be forwarded by fax to the medical assistance division immediately. (The medical assistance division of the human services department is responsible

for any notices related to medicaid payments sent to the provider.)

E. **NEW OWNERSHIP:** In the event a provider sells or otherwise transfers its interest in its certified program to another entity, and a sanction or other corrective measure is pending, the sale of the certified program does not stay or otherwise impact the pending sanction. The new owner/entity must comply with all areas of correction noted in the sanction or action plan. If a sanction(s) is pending, the LCA will proceed with the appeals process and may issue a notice of final action pursuant to these certification requirements.

[7.20.11.12 NMAC - Rp 7 NMAC 20.11.12, 03/29/02]

7.20.11.13 APPEALS AND HEARINGS:

A. **HEARING OFFICER:** The department appoints an impartial hearing officer to conduct any administrative appeal.

B. **PROCEDURES:** Adjudicatory Hearing procedures, 7.1.2 NMAC, apply in all administrative appeals.

C. **ADDRESS FOR REQUESTING AN ADMINISTRATIVE APPEAL:** All requests for appeal must be addressed to: Licensing and Certification Unit; Children's Behavioral Health and Community Services Bureau; Children, Youth and Families Department; Post Office Drawer 5160; Santa Fe, New Mexico 87502-5160 (facsimile 505-827-4595).

D APPEALS OF EMERGENCY SANCTIONS:

(1) If an emergency sanction is imposed, the LCA conducts a hearing within five business days of the Notice. The LCA notifies the agency of the name of the hearing officer and the date and time of the hearing.

(2) The emergency sanction takes effect immediately, and is not stayed by any request for administrative hearing or for an informal resolution conference.

(3) Any informal resolution conference, if requested, will be held within five business days of the date of the notice of emergency sanction.

E. APPEALS OF ADVERSE ACTIONS OTHER THAN EMERGENCY SANCTIONS:

(1) A program may appeal any adverse action set forth in a notice of contemplated action. The notice of contemplated action will include instructions and time frames for the program to request an appeal and/or an informal resolution conference. The program must request the appeal in writing within ten business days of receipt of the notice of contemplated action.

(2) When an appeal has been requested, the adverse action(s) is stayed until either of the following events occurs:

(a) the administrative hearing officer has conducted the hearing and issued an opinion; or

(b) the LCA and the program reach agreement through an informal resolution process.

(3) The administrative hearing will be held within 30 calendar days, unless both the LCA and the program agree to an extension. The LCA will inform the program of the date and location of the administrative hearing, and will identify the hearing officer.

(4) After the appeal process is concluded, or upon expiration of the time for appeal if no appeal is requested, the LCA will issue a notice of final action which will state the final decision of the LCA and the effective date of sanction(s) or any other adverse action. The notice of final action is not appealable.

F. **INFORMAL RESOLUTION CONFERENCE:** The department and the program may resolve any filed or potential administrative appeal through an informal resolution conference. The informal resolution conference provides an opportunity for the program to present new evidence or arguments regarding the deficiencies cited by, or corrective action proposed by, the department, and to present information regarding plans to remedy deficiencies and discuss possible pre-hearing disposition. The LCA has discretion to accept or reject any proposal made by the program. The informal resolution conference does not postpone any deadlines for appeal unless the LCA and the program both explicitly agree in writing to the extension.

[7.20.11.13 NMAC - Rp 7 NMAC 20.11.13, 03/29/02]

7.20.11.14 PROGRAM SURVEYS, INVESTIGATIONS, AND REPORTS:

A. Application for certification, whether initial or renewal, constitutes permission for entry into, and surveys of a program by the authorized LCA representatives at reasonable times while the application is pending.

B. LCA surveyors may enter the premises of an agency at any time and review any and all records of medicaid recipients, CYFD custody clients and agency staff; the LCA may conduct interviews with staff and/or clients in programs that are certified or required to be certified, whether or not an application for certification has been made, for the purpose of determining compliance with these certification requirements.

C. The LCA may conduct a survey(s) to assess/monitor progress with correction of violations found on previous surveys; or to investigate complaints or allegations of abuse, neglect or exploitation. The LCA may also conduct inquiry into matters of potential health and/or safety risk to clients as identified in serious incident reports or other information received by the LCA.

D. Findings made by the LCA during on-site surveys or investigations described in these certification requirements may result in changes of certification status, sanction(s), suspension, revocation, non-renewal, or denial of certification in accordance with all of the guidelines governing such actions as defined in these certification requirements.

E. When certification on-site surveys are conducted concurrently with licensing on-site surveys and there are violations found of both licensing and certification requirements that do not directly overlap, the LCA may issue a single report citing deficiencies with reference to both licensing and certification requirements.

F. When, during a certification survey, the LCA finds a violation(s) of these certification requirements that also constitute(s) a violation(s) of the licensing regulations of the department, the LCA may issue a single report addressing the violation(s) with reference to certification requirements only.

G. REPORTS:

(1) The LCA issues a written report of the findings for all required certification surveys within 30 business days of completion of the survey.

(2) When a survey is conducted for purposes of investigation, the LCA issues a report in instances of partial or fully substantiated complaint(s)/allegation(s) within 30 business days of the completion of the investigation.

(3) When a survey is conducted for purposes of investigation and the complaint(s)/allegation(s) are unsubstantiated, the LCA issues a letter indicating that the complaint was not substantiated, but does not issue a report.

(4) When a survey is conducted for the purposes of inquiry into questions of compliance arising from incident reports or other reports, the LCA may issue a report of any findings of noncompliance. If such a report is issued, it will be issued within 30 calendar days after completion of the survey.

(5) When a survey is conducted for purposes of following-up a monitoring plan, the LCA issues a follow up letter, but does not issue a report unless information obtained during such a visit indicates the need for a full program review and/or additional investigation(s).

(6) When a survey is conducted for purposes of technical assistance, the LCA does not issue a report.

(7) A report of a survey or investigation may be combined with a notice of contemplated action or notice of emergency sanction.

[7.20.11.14 NMAC - Rp 7 NMAC 20.11.14, 03/29/02]

7.20.11.15 CRIMINAL RECORDS CHECKS AND CLEARANCES:

A. Every program that provides child/adolescent mental health and/or substance abuse services pursuant to these certification requirements, operating in the state of New Mexico, must 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 agency must have received the criminal records clearance from the prevention and intervention division of the department 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. All agencies must 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 remain 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.

[7.20.11.15 NMAC - Rp 7 NMAC 20.11.15, 03/29/02]

7.20.11.16 PERSONNEL:

A. The agency provides personnel who are trained, supervised and in all respects qualified to perform the functions for which they are responsible.

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.

D. Orientation of personnel:

(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.

E. Personnel training, development, responsibilities and supervision:

(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) When 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.

F. Accountability:

(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.

G. Personnel records:

(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.

(2) The agency's 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.

(3) The agency's written policies provide personnel with access to their records and a process to review the record and to make additions and corrections to the record.

H. Schedules of direct service staff in day treatment and residential facilities:

- (1) Each facility or licensed unit maintains a written, legible schedule clearly identifying direct service staff responsible for care of clients.
- (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.

[7.20.11.16 NMAC - Rp 7 NMAC 20.11.16, 03/29/02; A, 10/29/04]

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

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 ventral 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, 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.

[7.20.11.17 NMAC - N, 03/29/02; A, 04/14/05]

7.20.11.18 AGENCY IN THE COMMUNITY:

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. Agency purpose: The agency's 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.

[7.20.11.18 NMAC - Rp 7 NMAC 20.11.18, 03/29/02]

7.20.11.19 AGENCY GOVERNANCE AND ADMINISTRATION:

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 agency's 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 therefrom 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.

[7.20.11.19 NMAC - Rp 7 NMAC 20.11.19, 03/29/02]

7.20.11.20 QUALITY IMPROVEMENT AND UTILIZATION REVIEW:

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.

[7.20.11.20 NMAC - Rp 7 NMAC 20.11.20, 03/29/02]

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

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).

[7.20.11.21 NMAC - Rp 7 NMAC 20.11.21, 03/29/02]

7.20.11.22 CLIENT PARTICIPATION, PROTECTION, AND CASE REVIEW:

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, 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.

[7.20.11.22 NMAC - Rp 7 NMAC 20.11.22, 03/29/02; A, 04/14/05]

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

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 is 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 establishes 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) that the agency makes all appropriate efforts to manage the child's behavior prior to proposing emergency discharge;
- (b) that 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.

[7.20.11.23 NMAC - Rp 7 NMAC 20.11.23, 03/29/02]

7.20.11.24 BEHAVIOR MANAGEMENT, PERSONAL RESTRAINT, AND SECLUSION

PRACTICES: 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, but in no case later than one hour after its initiation.

O. The following sub-section (O) 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) All agencies 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) Agencies 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 must 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.

[7.20.11.24 NMAC - N, 03/29/02]

7.20.11.25 MEDICATIONS:

A The agency establishes and follows 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 has controls in place for locked storage of medication and for access by authorized personnel.

F. The agency has controls 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 controls in 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).

[7.20.11.25 NMAC - Rp 7 NMAC 20.11.30.2, 03/29/02]

7.20.11.26 COMPREHENSIVE COMMUNITY SUPPORT SERVICES:

A. Comprehensive community support services (CCSS) shall coordinate and provide necessary services and resources to eligible clients and families to promote recovery, rehabilitation and resiliency.

B. These culturally sensitive services shall identify and address the barriers that impede the development of skills necessary for independent functioning in the community as well as strengths, goals and measurable objectives, which may aid the client or family in the recovery or resiliency process.

C. CCSS shall address goals as identified by the client or family specifically to meet recovery and resilience based outcomes in the areas of independent living, learning, working, socializing and recreation.

D. CCSS shall be provided to children, youth and adults with significant behavioral health disorders and who meet other criteria as identified by the collaborative.

E. CCSS shall be provided in compliance with the medical assistance division (MAD) definition of medical necessity and shall be furnished within the MAD benefits.

F. CCSS shall be furnished within the scope and practice of the provider's respective profession as defined by state law, and in accordance with applicable federal, state and local laws and regulations.

G. An assessment of baseline functioning shall be performed within 10 working days of the client's admission into CCSS services. The assessment shall evaluate and document the client's specific functional effectiveness in multiple skill domains based on the desired outcomes of the client or family.

(1) Functional level determination shall identify domains in which functional limitations precipitated by the behavioral health disorder are present. The diagnoses and assessments shall be the basis for the comprehensive client or family driven goal directed, measurable service plan

(2) CCSS eligible clients shall have one designated agency that will have the primary responsibility of partnering with the client and family for the purpose of implementing the comprehensive service plan.

H. Within the CCSS agency, a primary community support worker (CSW), under the documented supervision of the CCSS supervisor, shall be identified on the comprehensive service plan and shall partner with the client and family for the purpose of coordinating and facilitating recovery and resiliency directed team meetings. The CCSS supervisor shall sign, with name, credentials, and date, the initial service plan indicating that he has reviewed and approved the comprehensive service plan and each revision as it occurs.

I. Community support activities and relevant providers shall be clearly identified in the comprehensive service plan. The primary CSW shall coordinate the service plan without duplication by the other service providers. The CCSS comprehensive service plan shall be completed no later than 30 calendar days of the client's admission into CCSS services and specify recovery and resiliency strategies to include:

(1) the community support(s) and any other rehabilitative and treatment interventions needed for the client to achieve his specified service goals and to meet recovery and resiliency outcomes;

(2) the CCSS staff responsible for each recovery and resiliency intervention and the frequency of the planned interventions;

(3) the client's relevant diagnoses and other risk factors that place him at risk of further diagnoses;

(4) measurable goals and objectives identified by the client and family as their comprehensive service plan priorities to meet desired recovery and resiliency outcomes;

(5) a recovery/ resiliency management plan;

(6) a crisis management plan to address after-hours crisis situations including actions to be taken by client, family and natural supports;

(7) potential service plan barriers and applicable strategies; and

(8) if requested, advanced directives related to client's behavioral healthcare.

J. CCSS shall include the development of crisis plan interventions, as defined in an individual crisis plan, as a component of overall CCSS comprehensive service plan. If the client has or requests an advance directive, the crisis plan may be incorporated into the advance directive. The individualized crisis plan shall support the client and family in the management of crisis situations outside of regular business hours to develop or enhance the client's ability to make informed and independent choices.

(1) the crisis plan shall include the following requirements, which shall be formulated on admission to CCSS by the CCSS team, client, family, legal guardian and other interested parties.

(a) Risk assessment: Specify a process to assess potential risk and specify an algorithm of community resources to address by risk level that ranges from immediate (i.e. 911 or first responders) to intermediate (e.g. call to crisis line) to moderate (call for a clinic appointment). Specify a process to identify benchmarks that indicate when a crisis is appropriate reconciled.

(b) Client/family education: Provide the client and family education on community resources to be accessed during crisis situations. Each family and client shall be provided basic verbal communication techniques to help de-escalate a potential crisis situation.

(c) Internal communication: Crisis events are discussed in the CCSS team meeting to ensure all risk factors are identified and known by all team members.

(d) Face-to-face assessment: CCSS team member shall make a face-to-face visit as soon as possible, but no more than 48 hours after notification of a crisis, and complete an updated assessment for presentation to the team.

(e) Research past crisis situations for antecedent, precipitant, and consequent behaviors and discuss with the client or family to identify strategies or objectives likely to prevent crises.

(f) Identify alternative interventions that may be initiated during crisis situations, including pre-crisis or crisis instructions identified by the client or family.

(g) Incorporate client and family outcomes as benchmarks or measures of when the crisis is over.

(h) Revise crisis plan over time based on newly identified triggers and what is known to be effective.

(i) Document behavioral benchmarks (e.g., number of runs, self-injury, assaults, etc., and what worked).

(2) The negotiated crisis plan shall triage for differing levels of intensity and severity of crisis events and may identify other types of interventions that may include:

(a) residential services for stabilization;

(b) crisis respite services;

(c) wrap around services;

(d) increased family and community support specialist capacity to manage crisis situations;

(e) activation of advance directive instruction; and

(f) utilization of emergency room (ER) and other emergency response supports.

K. Every 90 days after implementation of the comprehensive service plan, the CCSS team, in partnership with the client and family, shall track and provide detailed documentation demonstrating progress made over time relating to the CCSS service goals, objectives and client/family designated recovery or resiliency outcomes. These shall be documented in the service plan updates with modifications made based upon barriers identified or redefined goals and objectives and future needs.

L. The follow up assessment shall document the current status of the client and family designated measurable recovery or resiliency functional outcomes.

M. Individualized CCSS interventions shall address the following objectives, as indicated in the assessment and comprehensive service plan:

(1) community services and resources available to support the client's achievement of his functional CCSS service goals and objectives;

(2) assistance in the development of interpersonal, community coping and functional skills (i.e., adaptation to home, school and work environments), utilizing evidence-based practices to support the skills development in the following domains:

(a) socialization skills;

(b) developmental issues as identified in the assessment;

(c) daily living skills;

(d) school and work readiness activities; and

(e) education and management of co-occurring illness;

(3) facilitating the development and eventual succession of natural supports in the workplace, housing/home, and social and school environments;

(4) provision of client and family education as appropriate regarding:

(a) self-management of symptom monitoring, illness management, and recovery and resiliency skills;

(b) relapse prevention skills;

- (c) knowledge of medication and potential side effects;
 - (d) motivational and skill development in taking medication as prescribed;
 - (e) ability to identify and minimize the negative effects of symptoms which potentially interfere with the client's activities of daily living; and
 - (f) as indicated, supports to the client to maintain employment and school or community tenure;
- (5) facilitating the client's abilities to obtain and maintain stable housing;
- (6) any necessary follow-up by the CSW to determine if the services accessed have adequately met the client's needs.
- N. Cultural competence shall be demonstrated by the CCSS provider through the agency's policies, procedures, training, outreach and advocacy efforts, and throughout the array of service delivery framework.
- O. The CCSS provider shall demonstrate through a documented internal quality monitoring process that on average (60% or more) of CCSS services are delivered face-to-face and in vivo (where client is in the community).
- P. The CSW shall provide routine follow-up to determine if the services accessed have adequately met the client's rehabilitative, recovery, resiliency, and treatment needs and document findings.
- Q. CCSS shall be offered at convenient times and locations to meet the needs of the client and family; the CCSS provider will actively work to eliminate language, financial, and other barriers to service.
- R. For clients and their families: The CSW shall make every effort to engage and partner with the client and family in achieving rehabilitative, recovery, and resiliency goals. Barriers to engaging the client or achievement of the service goals will be identified and utilized to amend the service plan interventions.
- S. When CCSS is provided by a certified peer or family specialist, CCSS functions shall be performed with a special emphasis on recovery and resiliency values and process, such as:
 - (1) empowering the client to have hope for, and participate in, his own recovery;
 - (2) assisting the client to identify strengths and needs related to attainment of independence in terms of skills, resources and supports, and to use available strengths, resources and supports to achieve independence;
 - (3) assisting the client to identify and achieve his personalized recovery and resiliency goals; and
 - (4) promoting the client's responsibility related to illness self-management.
- T. CCSS shall be subject to the limitations and coverage restrictions as defined by 8.315.6 NMAC, Comprehensive Community Support Services.
- U. Behavior management skills development service (BMS) interventions are distinct and different from CCSS and shall not be considered to be CCSS.
- V. **Eligible providers:** CCSS shall be delivered by a certified mental health agency.
 - (1) The agency shall be a legally recognized entity in the United States, qualified to do business in New Mexico, and shall meet standards established by the state of New Mexico or its designee, and requirements of the funding source.
 - (2) CCSS shall be provided in the following type of entities:
 - (a) federally qualified health center (FQHC);
 - (b) Indian health service (IHS) hospital or clinic;
 - (c) tribal-638 hospital or clinic;
 - (d) community mental health center
 - (e) core service agency (CSA); or
 - (f) an agency otherwise certified as a CCSS agency by New Mexico children, youth and families department (CYFD) or New Mexico department of health (DOH)
 - (3) Eligible clients who are 18 through 20 years of age may be served by an agency certified for CCSS by CYFD or DOH, as indicated.
- W. **Staff qualifications:** Clinical services and supervision by licensed behavioral health practitioners shall be in accordance with their respective licensing board regulations.
 - (1) Minimum staff qualifications for the CSW:
 - (a) shall be a minimum of 18 years of age; and
 - (b) shall hold a bachelor's degree in a human service field from an accredited university and one (1) year relevant experience working with the target population; or
 - (c) shall hold an associate's degree in a human service field from an accredited college and have a minimum of two (2) years of experience working with the target population; or
 - (d) shall be a high school graduate or have a general education development (GED) and shall

have a minimum of three years of experience working with the target population; or

- (e) shall be certified as a certified peer specialist (CPS) or certified family specialist (CFS).
- (2) Minimum staff qualifications for the CCSS program supervisor:
 - (a) shall hold a bachelor's degree in human services field from an accredited university;
 - (b) shall have a four (4) years relevant experience working with the target population; and
 - (c) shall have one year demonstrated supervisory experience.
- (3) Minimum staff qualifications for the clinical supervisor (The clinical supervisor and the CCSS program supervisor may be the same individual):
 - (a) shall be a licensed independent practitioner (i.e., psychiatrist, psychologist, LISW LPCC, LMFT, psychiatrically certified CNS) practicing within the scope of their New Mexico licensure;
 - (b) shall have one year documented supervisory experience; and
 - (c) shall provide documented clinical supervision on a regular basis to the CSW, CPS and CFS.
- (4) Minimum staff qualifications for CPS:
 - (a) shall be a minimum of 18 years of age;
 - (b) shall have a minimum of high school diploma or GED;
 - (c) shall be self-identified as a current or former consumer of mental health or substance abuse services and have at least one year of mental health or substance abuse recovery; and
 - (d) shall have received certification as CPS.
- (5) Minimum staff qualifications for CFS:
 - (a) shall be a minimum of 18 years of age;
 - (b) shall have a minimum of high school diploma or GED;
 - (c) shall have personal experience navigating any of the child-family-serving systems or advocating for family members who are involved with the behavioral health systems; shall have an understanding of how these systems operate in New Mexico;
 - (d) if the individual is a current or former consumer, he shall be well-grounded in his symptom self-management; and
 - (e) shall have received certification as a CFS.

X. Staff training requirements:

- (1) The minimum CCSS staff training completed for all CSWs shall be documented in the personnel record and include:
 - (a) an initial training comprised of 20 hours of documented training or education drawn from an array of the following areas, to be completed within the first 90 days of employment as a CSW:
 - (i) clinical and psychosocial needs of the target population, including cultural competency with regard to race, religion, national origin, sex, physical disability and other community-specific characteristics;
 - (ii) psychotropic medications and possible side effects;
 - (iii) drugs of abuse and related symptoms;
 - (iv) crisis management;
 - (v) principles of recovery, resiliency and empowerment;
 - (vi) ethical and cultural considerations;
 - (vii) community resources and services, including pertinent referral criteria;
 - (viii) client and family support networking;
 - (ix) mental health or developmental disabilities code;
 - (x) children's code;
 - (xi) client and family centered practice;
 - (xii) behavioral management;
 - (xiii) treatment and discharge planning with an emphasis on recovery and crisis planning.
 - (b) documentation of ongoing training is required and maintained in the personnel record and comprised of 20 hours per year, commencing after the first year of hire, with content of the education based upon agency assessment of staff's needs. Such assessment shall be monitored and documented through the agency's continuous quality improvement program and annual plan.
- (2) Minimum staff training requirements for supervisors shall be documented in the personnel record and include:

(a) the same 20 hours of documented training or continued education as required for the CCSS CSW;

(b) a minimum of eight hours of training specific to supervisory activities; and

(c) documentation of ongoing training comprised of 20 hours is required of a CCSS supervisor every year, commencing after the first year of hire, with content of the education based upon agency assessment of staff's needs. Such assessment shall be monitored and documented through the agency's continuous quality improvement functions.

Y. Case loads:

(1) Caseloads, on average, shall not exceed a ratio of 1:20 (one CSW to 20 clients receiving CCSS).

(2) Clients participating in medication management as the primary focus of service are not subject to the client- staff ratio.

(3) CSW caseloads, of client to staff ratio of 1:20 on average, shall be monitored and documented through the agency's internal continuous quality improvement program through defined periodic review activities such as peer chart reviews to ensure the agency is in caseload compliance. The agency will implement timely corrective action when it is identified that staff ratio averages are not in compliance.

(4) Detailed case notes document all CCSS service intervention activities and locations of services provided for each service span delivered and include the CCSS worker's name, credential and date of the service delivery.

Z. Documentation requirement:

(1) The CCSS provider shall be responsible for consistent documentation of all service delivery.

Each service delivery case note shall include but not be limited to:

(a) date of service;

(b) service location;

(c) duration of service span (e.g., 1:00-2:00pm);

(d) description of the service provided with reference to the comprehensive service plan and related service goal and objective; and

(e) the client's name, and signature and credential of the individual delivering the service.

(i) All CCSS file documentation shall be legible.

(ii) All CCSS service delivery shall be consistent with the service definition

requirements.

(2) CCSS comprehensive service plan and service delivery documentation shall be internally monitored through the agency's continuous quality improvement functions at least quarterly to ensure compliance with all of the certification requirements.

[7.20.11.26 NMAC - Rp 7 NMAC 20.11.25, 03/29/02; A, 12/31/08]

7.20.11.27 DAY TREATMENT SERVICES:

A. Day treatment services as defined herein are provided in a school or other community setting and are distinct from partial hospitalization services provided in a psychiatric hospital. Education services are provided through the public school system or through a New Mexico accredited private school in coordination with the day treatment services.

B. Personnel:

(1) Direct service staff may be unlicensed or uncertified paraprofessionals such as teacher aides, mental health workers, psychiatric technicians or similar direct service workers. At least one staff member who has received all training required in 27.B (a) through (f) is present during program hours. The direct service staff receives documented clinical supervision for a minimum of two hours per month. The agency's direct service staff must have at least a high school education or GED and 20 hours of documented pre-service training, including, but not limited to crisis management/intervention, behavior management, and emergency procedures, that include current CPR and first aid certificates. Within 90 days of hire, the staff will receive an additional 20 hours of documented training, including but not be limited to:

(a) etiology and symptoms of emotional disturbances and neurobiological disorders;

(b) family systems;

(c) basic communication and problem solving skills;

(d) child and adolescent development;

(e) issues related to ethnic and cultural considerations of the clients served; and

(f) action and potential side effects of medications.

(2) Clinical director:

(a) Clinical director qualifications: The clinical director possesses one of the following New Mexico licenses; physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, licensed independent social worker (LISW), licensed master social worker (LMSW), clinical nurse specialist in child psychiatric nursing, registered nurse (RN) with a master's degree in psychiatric nursing, licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), or licensed independent school psychologist.

(b) In addition to having one of the above licenses, the clinical director is required to have a minimum of two years of experience in clinical practice with children, adolescents and families.

(c) Clinical director responsibilities: The responsibilities of the clinical director are to provide clinical oversight of the services, as well as to provide supervision, support, and consultation to all agency direct service staff.

(3) Clinical supervisor:

(a) Clinical supervisor qualifications: The clinical supervisor possesses one of the following New Mexico licenses: physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, licensed independent social worker (LISW), clinical nurse specialist in child psychiatric nursing, registered nurse (RN) with a master's degree in psychiatric nursing, licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), or licensed independent school psychologist.

(b) In addition to having one of the above licenses, the clinical supervisor is required to have a minimum of two years of experience in clinical practice with children, adolescents and families.

(4) Therapist: Therapist qualifications: The therapist possesses one of the following New Mexico licenses: Physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, licensed independent social worker (LISW), licensed master social worker (LMSW), clinical nurse specialist in child psychiatric nursing, registered nurse (RN) with a master's degree in psychiatric nursing, licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), licensed independent school psychologist, licensed professional mental health counselor (LPC), licensed professional art therapist (LPAT), licensed entry level school psychologist, or licensed mental health counselor (LMHC).

C. Services:

(1) Assessment and treatment planning conform to Section 23 of these certification requirements.

(2) The agency provides adequate care and continuous supervision of the client at all times in accordance with the client's developmental and clinical needs.

(3) The structured program of care is scheduled for a minimum of four hours per day, two to five days per week based on the acuity and the clinical needs of the client and family. The agency provides the following, pursuant to the client's treatment plan:

(a) individual, family, group or other therapy, in whatever combination is appropriate to meet the needs of the client;

(b) other services as provided in the treatment plan;

(c) development of life skills activities;

(d) crisis intervention;

(e) therapeutic recreation, when indicated by the child's needs;

(f) documentation of services provided, and of the client's progress or lack thereof on each day that service is provided.

(4) The agency documents that:

(a) the child has access to the appropriate educational services;

(b) the child has opportunities for involvement in community, social, athletic and recreational programs;

(c) the child has opportunities to pursue personal, ethnic or cultural interests; and

(d) advance schedules are posted for structured and supervised activities which include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and emotional needs of the client pursuant to the treatment plan.

(5) The agency maintains a written agreement with the public school district or private school so that appropriate educational services are provided to clients in the day treatment services program.

[7.20.11.27 NMAC - Rp 7 NMAC 20.11.26, 03/29/02]

7.20.11.28 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES:

A. Behavior management skill development services are delivered through an individualized behavior management skills development service plan designed to develop, restore, or maintain skills and behaviors that result in improved function or which prevent deterioration of function. Behavior management skills development services are delivered to clients up to age 21 who:

- (1) are in need of behavior management skills development intervention to avoid inpatient hospitalization, residential treatment or separation from his/her family; or
- (2) require continued intensive or supportive services following hospitalization or out-of-home placement as a transition to maintain the client in the least restrictive environment possible.

B. Personnel

- (1) The behavior management skills development specialist meets the following criteria:
 - (a) is at least 21 years of age; and
 - (b) demonstrates the ability to independently implement and document the outcome of the goals, measurable objectives and interventions as defined in a behavioral management skills development service plan.
- (2) The behavior management skills development specialist receives 20 hours of documented pre-service training, to include, but not limited to:
 - (a) crisis management/intervention;
 - (b) behavior management;
 - (c) emergency procedures, which include current CPR and first aid certificates.
- (3) Within 90 days of hire, the behavior management skills development specialist receives an additional 20 documented hours of training, including but not limited to:
 - (a) etiology and symptoms of emotional disturbances and neurobiological disorders;
 - (b) family systems;
 - (c) basic communication and problem solving skills;
 - (d) child and adolescent development;
 - (e) issues related to ethnic and cultural interests of the clients served;
 - (f) action and potential side effects of medications.
- (4) Behavior management skills development specialists receive supervision by a New Mexico licensed practitioner with a doctoral or master's degree from an accredited institution in a human service related field who has at least two years experience working with children, adolescents and families. Exception: If a supervisor with the above qualifications cannot be recruited, the supervisor must possess, at a minimum, a B.S.W., B.A., B.S., or B.U.S. in a human service related field plus four years experience working with seriously emotionally disturbed or neurobiological disordered children and adolescents.
- (5) Supervision is provided for a minimum of two hours per month depending upon the complexity of the needs presented by clients and the supervisory needs of the behavior management skills development specialist. Supervision is documented with dates, times, and content of contacts.

C. Services:

- (1) Behavior management skills development services focus on acquisition of skills and improvement of the client and/or family's performance related to targeted behaviors. The agency:
 - (a) conducts a clinical assessment, or acquires clinical information that guides the development of the behavior management skills development services plan;
 - (b) documents clinical review of information that enables the agency to complete the behavior management skills development service plan;
 - (c) develops a behavior management skills development service plan, including: client needs, measurable goals, interventions, discharge criteria, and a discharge plan, within 14 days of admission to the service;
 - (d) reviews the behavior management skills development service plan every 30 days and revises as necessary; and
 - (e) works in partnership with other agencies or individuals involved in the client's care to implement the discharge plan and link the client to aftercare, as indicated;
 - (f) provides services to one or more child(ren) from the same or different home(s), provided that a staff-to-client ratio of 1:1 is maintained at all times.
- (2) The behavior management skills development specialist provides the following services:
 - (a) participation in the development, review and revision of the behavior management service plan;

- (b) implementation of the behavior management skills development service plan to include teaching of behavior enhancing skills;
 - (c) documentation of each client contact, including date, time, duration, and the client's progress and/or response to the interventions each day service is provided, stated in terms of service plan goals and objectives; and
 - (d) coordinating with the family and school personnel, if appropriate, to assist the client to achieve and/or to maintain appropriate behavior management.
- [7.20.11.28 NMAC - Rp 7 NMAC 20.11.27, 03/29/02]

7.20.11.29 TREATMENT FOSTER CARE SERVICES:

A. Treatment foster care services, Level I and Level II, are specifically designed to accommodate the needs of psychologically or emotionally disturbed and/or behaviorally disordered clients. Eligible clients are those who are at risk for failure or have failed in regular foster homes, are unable to live with their own families, or are going through a transitional period from residential care as part of the process of return to family and community.

(1) Treatment foster care services, level I and II, are targeted to children who meet the following criteria:

- (a) are at risk for placement in a higher level of care or are returning from a higher level of care and are appropriate for a lower level of care; or
- (b) have complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and
- (c) require, and would optimally benefit from, the behavioral health services and supervision provided in a treatment foster home setting.

(2) Treatment foster care services level II (TFC II) Services are targeted to children who, besides, meeting the criteria in 29.A.1. (A). (c), also meet one of the following criteria:

- (a) have successfully completed treatment foster care services level I (TFC I), as indicated by the treatment team; or
- (b) require the initiation or continuity of the treatment and support of the treatment foster family to secure or maintain therapeutic gains; or
- (c) require this treatment modality as an appropriate entry level service from which the client will optimally benefit.

(3) A client eligible for treatment foster care services, level I or level II, may change treatment foster homes only under the following circumstances:

- (a) an effort is being made to reunite siblings; or
- (b) a change of treatment foster home is clinically indicated, as documented in the client's record by the treatment team.

B. Personnel qualifications and responsibilities:

(1) Treatment coordinator qualifications: The treatment coordinator possesses one of the following: a master's degree from an accredited program in social work or another human-services field; or a bachelor's degree in social work or another related human-service field and two years experience with this population.

(2) Treatment coordinator responsibilities:

(a) Treatment planning: Under supervision, and in coordination with the rest of the treatment team, the treatment coordinator:

- (i) prepares the initial and comprehensive treatment plans in accordance with the timelines established in these certification requirements;
- (ii) coordinates the implementation of the treatment plan;
- (iii) monitors the client and his/her situation for events related to the treatment plan or otherwise significant to provision of treatment;

(iv) documents revisions to the treatment plan;

(v) assures that all members of the treatment team, including the client as clinically indicated, participate in the treatment planning process, as documented by the signatures of treatment team members on the treatment planning documents; and

(vi) involves the client's parents or legal guardians in treatment team meetings and in all plans and decisions affecting the client and keeps them informed of the client's progress in the program unless prohibited by the court or otherwise contraindicated according to documentation in the client's record.

(b) Contact with client: The treatment coordinator has a private face-to-face visit with the

client within the first two weeks of placement, and at least twice monthly thereafter for TFC I clients and once monthly for TFC II clients. These contacts are conducted both in-home and out-of-home.

(c) Contact with treatment foster parent(s): The treatment coordinator has a face-to-face interview with the client's treatment foster parents within the first two weeks of placement and at least twice monthly thereafter TFC I clients and once monthly for TFC II clients. The treatment coordinator has a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week that face-to-face contact has been made.

(d) All contacts are documented in the client's record and include a summary related to the treatment plan, significant events and the communications between treatment coordinator, client, treatment parent(s) and the biological/adoptive family. All documentation includes the date, time, location of the contact, and names of persons present.

(e) Support of the client's relationship with his or her biological/adoptive family: The treatment coordinator supports and enhances the client's relationship with his or her family to the extent determined by the treatment team. The treatment team reviews any restrictions at the time of the writing of the comprehensive treatment plan or at the time the restriction is imposed. The treatment coordinator documents in the client's case record the reason(s) for any restriction, and the treatment team's involvement. Thereafter, the restriction is reviewed at least every 30 days and documented in the treatment plan review.

(f) Assistance to treatment foster parents: The treatment coordinator assists the treatment foster parents in the implementation and development of treatment strategies, including goal-setting and planned interventions. This assistance is done through the following:

- (i) the provision of ongoing client-specific training and problem solving;
- (ii) facilitation of professional development training for the treatment foster parents as described in Section 29.B(10) of these certification requirements;
- (iii) observation/assessment of family interactions;
- (iv) assessment of safety issues involving the client(s) in the home.

(g) Community liaison and advocacy: Based upon an assessment of the client's and biological/adoptive family's needs, the treatment coordinator advocates for and coordinates the provision of community-based services, as related to identified goals, and provides technical assistance to community providers as needed to maximize the utilization of services by the client and family.

(h) A treatment coordinator is physically available within 60 minutes of a treatment foster home so that quality of care, appropriate supervision and timely responsiveness to the treatment foster family are possible.

(3) Clinical supervisor qualifications: An individual providing supervision to the treatment coordinator possesses one of the following New Mexico licenses: Physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, registered nurse (RN) with a masters degree in psychiatric nursing, clinical nurse specialist in a related field, licensed independent social worker (LISW), licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT) or other licensed independent practitioner in a related field. In addition to having one of the above licenses, the clinical supervisor is required to have a minimum of three years experience in clinical practice with children, adolescents and families.

(4) Clinical supervisor responsibilities: The role of the clinical supervisor is to provide support, consultation and oversight to the treatment coordinator(s) and therapist(s) through a minimum of four hours of supervision each month.

(a) The clinical supervisor is responsible for supervising ongoing treatment planning and implementation of the treatment plan for each client. The clinical supervisor evaluates progress in treatment and signs the treatment plan documents.

(b) The clinical supervisor provides coordination and back up coverage allowing for 24-hour on-call crisis intervention services for treatment parents, clients and their families.

(c) The clinical supervisor monitors the caseload of each treatment coordinator, and monitors each treatment coordinator in fulfilling his/her responsibilities. The maximum number of treatment foster care Services client(s) that maybe assigned to a single treatment coordinator shall not exceed eight. Caseloads are reduced based on case complexity, travel times and non-direct service times. The actual number of clients in a single caseload is based upon the ability of the treatment coordinator and/or agency to meet all applicable regulations as well as on the following considerations:

- (i) the difficulty of the total client caseload; including the amount of time needed for

support of, contact with, and assistance to the treatment foster parent(s) based on the complexity of client needs;

- (ii) the availability of paraprofessional support and assistance;
- (iii) the skills and abilities of the treatment foster parent(s);
- (iv) geographical areas to be served; and
- (v) additional duties assigned to the treatment coordinator.

(5) **Therapist qualifications:** Therapists providing individual, family, and/or group therapy meet either the necessary licensing qualifications as listed for clinical supervisor or possess one of the following New Mexico licenses: Licensed master social worker (LMSW), licensed professional mental health counselor (LPC), licensed art therapist (LAT) or licensed mental health counselor (LMHC).

(6) **Therapist responsibilities:** The therapist provides individual, family and/or group psychotherapy to clients as described in the treatment plan. The therapist documents all therapeutic contacts in the client's record. Therapy notes will be kept current and submitted to the treatment coordinator for inclusion in the client's record within one week of the session date. The therapist is an active treatment team member and participates fully in the treatment planning process.

(7) **Supervision/consultation:** An independently-licensed therapist consults with the supervisor for a minimum of two times per month. A non-independently licensed therapist receives supervision from the supervisor at a minimum of two times per month. All consultation/supervision is documented with the date, time, duration, and topics discussed.

(8) **Staff training:**

(a) Therapists, treatment coordinators, and other professional staff participate in knowledge/skill based pre-service training relevant to the services provided including:

- (i) child and adolescent development;
- (ii) prevention and de-escalation of aggressive behavior and the use of therapeutic holds;
- (iii) crisis management, and intervention;
- (iv) grief and loss issues for client(s) in foster care;
- (v) cultural competence and knowledge of the means for obtaining and providing

culturally responsive services;

- (vi) specific agency policies and procedures including documentation;
- (vii) recognition of abuse/neglect symptoms and state abuse/neglect/exploitation

reporting requirements;

- (viii) actions and potential side-effects of medications;
- (ix) certification in emergency first aid and CPR; and
- (x) behavior management.

(b) Professional staff who can provide verifiable documentation of previous training in one or more of the above areas are not required to repeat the training if the staff and the clinical supervisor agree in writing as to which specific training is equivalent and therefore not required. This exception does not apply to training regarding an agency's policies and procedures.

(c) All professional staff attend annual, ongoing professional development/ training relevant to the agency's treatment foster care model and to their individual job responsibilities.

(9) **Treatment parent qualifications/requirements:** Prior to hiring or contracting with prospective treatment foster parents, the agency documents that each prospective treatment foster parent, including those who provide therapeutic leave, meets and conforms to the certification requirements set forth in 8.27.3 NMAC (Licensing Requirements for Treatment Foster Care Services), as well as the following qualifications and requirements:

(a) hold a current and valid license as treatment foster parent issued by an agency licensed by the department as a child placement agency. No home can be licensed for treatment foster care services until any previous foster care license is surrendered to the issuing agency;

(b) have signed a release of information that permits the department to share with the treatment foster care services agency a summary of any substantiated complaints involving abuse/neglect pertaining to the prospective treatment foster family;

(c) have signed a release to allow the agency to read prior foster home and prior treatment foster home records that exist through any previous foster home licensure or certification;

(d) understand the placement in treatment foster care services as temporary, except when adoption by the treatment foster parents has become the permanency plan;

(e) have access to reliable transportation, and when driving a car have a valid New Mexico

driver's license and liability insurance;

(f) have read, expressed understanding of, and agreed in writing to fulfill the requirements and responsibilities of a treatment foster parent;

(g) prior to hiring or contracting with prospective treatment foster parent(s), the agency documents that it has requested and reviewed the prospective parent(s)' substantiated reports of abuse/neglect, if any, and previous foster-parent records, if any, and determined that such history does not disqualify the prospective parent(s) from becoming treatment foster parent(s); the agency will inquire about any previous treatment foster care services or regular foster care experience applicant families may have had.

(10) Treatment parent training: The training of treatment foster parents is systematic, planned, documented and may include modalities other than didactic instruction. Training is consistent with the program's treatment philosophy and methods and equips treatment foster parents with the skills to carry out their responsibilities as agents of the treatment process. Prospective treatment foster parents are provided with a written list of duties clearly detailing their responsibilities prior to their approval by the program. The written professional development plan is placed in the treatment foster parent(s) record.

(a) All treatment foster parents receive 40 hours of training, at least 30 hours of which are completed prior to placement of client(s). Any remaining hours are completed within two months of first placement. The training, at a minimum, includes:

(i) first aid and CPR training, provided by a certified instructor before receiving a client for placement;

(ii) child and adolescent development;

(iii) behavioral management;

(iv) prevention and de-escalation of aggressive behavior and the use of therapeutic holds;

(v) crisis management/intervention;

(vi) grief and loss issues for client(s) in foster care;

(vii) cultural competence and culturally responsive services;

(viii) specific agency policies and procedures including documentation,

(ix) recognition of abuse/neglect symptoms, and State abuse/neglect/exploitation reporting requirements;

(x) side-effects of psychotropic medication; and

(xi) role of treatment foster parent in treatment planning.

(b) Treatment foster parents who can provide verifiable documentation of previous training in one or more of the above areas are not required to repeat the training if the staff and the clinical supervisor agree in writing which specific training is equivalent and therefore not required. This exception does not apply to training regarding an agency's policies and procedures.

(c) Twenty-four hours of inservice training is required annually after receiving a client for placement. The 24 hours may include:

(i) up to four hours of video when supplemented by discussion in a classroom or clinical training setting;

(ii) up to four hours of supplemental reading may be part of the 24-hour annual inservice training when supplemented by discussion in a classroom or clinical training setting.

(11) Treatment foster parent responsibilities: The treatment foster parents works with the treatment team and with agency supervision to develop and implement the treatment plan. Treatment foster parents provide front-line treatment interventions. The family living experience is the basic service to which individualized treatment interventions are added. Treatment foster parents are responsible for meeting the client's basic needs, and providing daily care and supervision. In addition to their basic foster parenting responsibilities, treatment foster parents perform the following tasks and functions:

(a) Treatment planning: Treatment foster parents actively participate in the treatment planning process and implement specified provisions of the treatment plan.

(b) Treatment foster parents work with the treatment team to maximize the likelihood that all services are provided in a culturally competent and culturally proficient manner.

(c) Contact with the client's family: Unless contraindicated in the client's treatment plan, or by court order, treatment foster parents assist the client in maintaining contact with his or her family, and actively work to support and enhance those relationships. When reunification with the client's family is planned, the treatment foster parents work in conjunction with the treatment team toward the accomplishment of the reunification

objectives outlined in the treatment plan.

(d) Permanency planning assistance: The treatment foster parents assist with efforts specified in the treatment plan to meet the client's permanency planning goal(s).

(e) Record keeping: The treatment foster parents systematically record information and document client behaviors/activities and significant events related to the treatment plan. Documentation occurs on a weekly basis at a minimum, and more often in response to the occurrence of significant events. Daily logging is preferable.

(f) Agency contact: The treatment foster parents keep the agency informed of the occurrence of significant events. Daily logging is preferable.

(g) Confidentiality: Treatment foster parents maintain agency standards of confidentiality.

(h) Incident reporting: Treatment foster parents report all serious incidents to the agency, consistent with agency policy and certification requirements.

(i) Availability: At least one treatment foster parent is readily accessible at all times and is able to be physically present, if necessary, to meet the client's emotional and behavioral needs; e.g., a treatment foster parent responds if the school requires immediate parental attention. A single treatment foster parent may not schedule work hours when a client is normally at home.

(j) Care and supervision: Treatment foster parents ensure that proper and adequate supervision is provided at all times. Guardians ad litem, court-appointed special advocates, and CYFD employees may meet privately with clients as necessary. Clients are not left in the care or unsupervised presence of friends, relatives, neighbors, or others who have not received both criminal records clearance and training. Treatment teams determine that all out-of-home activities are appropriate for the client's level of need, including the need for supervision.

(k) Community-based resources: The treatment foster parents work with all appropriate and available community-based resources to secure services for and/or advocate for the client(s).

B. Assessment, pre-placement, and placement: Prior to placement of any treatment foster care client in any home, including therapeutic leave or interim placement, the agency will determine that the placement is therapeutically appropriate. The placement process includes documented consideration of the home and all residents.

(1) The comprehensive assessment includes face-to-face interviews with the client; with the client's biological or adoptive family whenever possible and when not contraindicated; and contact with any previous care providers. The comprehensive assessment meets the following requirements, in addition to those listed in the general provisions:

(a) the client's and his/her family's priorities and concerns, as appropriate, are documented; and

(b) if the client is in department custody, the agency requests information from the client's social worker, including the permanency plan, collateral assessment(s), and any known or suspected history of abuse/neglect.

(2) Placement does not occur until after a comprehensive assessment of how the prospective treatment foster family can meet the client's needs and preferences, and a documented determination by the agency that the prospective placement is a reasonable "match" for the client.

(3) A documented match assessment includes, but is not limited to:

(a) the identified needs of the client;

(b) the strengths of the treatment foster parents to implement the client's specific services and treatment plan;

(c) composition of the treatment foster family; including the name, age, and gender of each person residing in the home or visiting on a regular basis;

(d) treatment foster parents' specific knowledge, skills, abilities and attitudes as related to the specific needs of each client including high risk behaviors or the potential for such;

(e) treatment foster family's ability to speak the primary language of the client;

(f) treatment foster family's willingness and ability to work with the client's family;

(g) proximity of the treatment foster parent to the client's family, friends and school. If the client is placed more than an hour's driving time from the family, the justification is documented in the client's record;

(h) client and client's family's (if applicable) preference for placement;

(i) availability of, and access to, community resources required to meet the client's needs; and

(j) a summary/rationale of the client's placement in the particular treatment foster home chosen; the clinical rationale includes consideration of all residents of the home, including anticipated effects of the placement on all clients present and potential health and safety risks, and is documented in each client record prior to the placement.

(4) Pre-placement processes:

(a) Prior to placement, the client's family of origin meets with his or her child's prospective treatment foster parent(s) unless clinically contraindicated, prohibited by court order, or prevented by refusal or unavailability. If a pre-placement meeting does not occur, the reasons are documented in the client's record.

(b) Following completion of the match assessment, the client visits with the treatment foster family for a full 72 hours. The dates and times of the visit are documented in the client's record. At the end of the 72 hours, the treatment coordinator documents an assessment of the visit and the therapeutic appropriateness of the match, including the client's reaction and the treatment foster parent(s) response. When it is clinically indicated, the client may remain in the placement at the end of the 72-hour visitation, provided that the clinically-based reasons are documented in the client's record.

(c) All information that the treatment foster care services agency receives concerning a client waiting for placement is explained to the prospective treatment foster family prior to placement. Prospective treatment foster parents are responsible for maintaining agency standards of confidentiality regarding such information.

(d) For all clients in the custody of the department, the treatment foster care services agency shares the home study of a prospective licensed treatment foster family with the client's department social worker and invites the social worker to meetings in which the prospective placement is discussed.

(e) The treatment foster parent(s) can refuse placement of any treatment foster client whom they consider inappropriate for the home or to protect the safety of any children currently in the home.

(f) Treatment home composition and capacity, including capacity for therapeutic leave: Prior to any placement, the agency determines that the match is consistent with the following limits:

(i) A Treatment foster family is eligible to care for level I and level II treatment foster clients, non-treatment siblings of treatment clients, and/or children who were previously treatment foster clients in the same home, but are no longer qualified for TFC. Non-treatment regular foster or shelter care children may be temporarily placed in the home for therapeutic leave or shelter care for up to 30 days, after the agency assesses and documents that such a temporary placement will not compromise the treatment of any current client. Regular foster care children who were in the home previously or foster children who are siblings or children of treatment foster clients currently in the treatment foster home may be placed without the 30 day limit pertaining to therapeutic leave or shelter care clients. Arrangements pertaining to placement of regular foster children are made with the department social worker.

(ii) The total number of children in a treatment foster care services home, including treatment foster care clients, therapeutic leave children, and any other children, may not exceed six, except in rare circumstances such as placing sibling groups together. Such exceptions are approved in advance by the treatment teams, guardians of all children, and by the agency's clinical director. The clinical rationale for the exception is documented in each client's record.

(iii) The total number of treatment foster clients placed in a two-parent treatment foster care home is limited to three. At no time may more than two TFC I children be placed in the same home, except when they are siblings. In the case of multiple treatment foster care children placements, at least one treatment foster care parent will not be employed outside the home.

(iv) The total number of treatment foster care clients placed in a single-parent treatment foster care home cannot exceed two. No more than one level I treatment foster care client may be placed in a single-parent treatment foster care home, unless both are siblings.

(g) The agency obtains written agreement of the treatment team, including Guardians ad Litem (GALs), and legal guardians, for all placements.

(h) A client with a history of more than one incident of substantiated sexual aggression may not be placed in a home with any other client, including client(s) temporarily present for therapeutic leave or shelter purposes, without prior written approval by the treatment teams of all treatment clients in the home. In the case of non-treatment minors, written permission must be obtained from the legal guardian(s) prior to such placement. The rationale for such placement will distinguish the sexually reactive from the sexually aggressive client. The sexually reactive child may have presented with a history of symptoms such as public masturbation, sex play and/or developmentally incongruent preoccupation with sexual matters or topics. This behavior by itself should not

present a barrier to the placement of other children. The sexually aggressive child has had more than one incident of using force or intimidation to make another child comply with a sexual activity. The treatment team is responsible for evaluating all collateral information, evaluating any high risk behaviors or the potential for such, regardless of when it occurred or when an evaluation was performed, and the severity of the force or intimidation, regardless of how recently it occurred, prior to placing the child in a home where there are other children.

(i) The agency trains the treatment foster family in cultural and physical care issues related to the client's race and culture prior to the client's placement.

(5) Therapeutic leave: Agency policy and practice provide for treatment foster parent(s)' access to therapeutic leave, both planned and crisis-based.

(a) Treatment foster parents providing therapeutic leave placements are licensed and trained by the agency, are given a copy of the client's treatment plan, and are supervised by the treatment coordinator in the implementation of the in-home strategies.

(b) Therapeutic leave placements may be provided by a licensed and appropriately trained treatment foster family from another licensed and certified treatment foster care services agency, provided that the placing agency ensures the client's treatment plan is implemented appropriately.

(c) It is the treatment foster care services agency's responsibility to determine that treatment foster parents into whose home a therapeutic leave client has been placed are sufficiently skilled to work with the mix of treatment clients in their home, and document this determination in their records prior to placement.

(d) If a treatment foster care services agency cannot secure a trained and licensed treatment foster care family to provide therapeutic leave for a client, the agency may place the client in a licensed residential treatment services or licensed group home services, if clinically appropriate and documented, for a period not to exceed seven days. The residential treatment services or group home services program must adhere to the client's treatment plan and document the services provided and the client's behavior, consistent with these certification requirements for treatment foster parent documentation.

(e) Therapeutic leave placements comply with all certification requirements stated herein, including capacity limits. The agency documents assessment of treatment home/family composition, physical and sexual safety issues, and language(s) spoken, prior to therapeutic leave placement.

D. Service planning and provision:

(1) All treatment foster care services, as described in these certification requirements, are the responsibility of the treatment foster care services agency. Services are furnished either through agency staff or contracted persons.

(2) The treatment foster care services agency provides intensive support, technical assistance, and supervision of all treatment foster parents.

(3) The agency provides clinically appropriate therapy services to the client, and involves the treatment foster parents and the client's family to achieve the goals of the treatment plan. Each treatment client receives regularly scheduled therapy, including family therapy, as clinically indicated and specified in the client's treatment plan. Family involvement in treatment, including family therapy is not required when contraindicated by court order, or temporarily contraindicated by the clinical judgement of the department's legal guardian or treatment team.

(a) Therapy cannot be suspended or terminated unless there is concurrence by the treatment team that therapy is not presently indicated.

(b) All efforts are made to place a client in close enough proximity to biological/adoptive family so that family therapy will not be hindered.

(c) Family therapy is required when reunification is the goal.

(d) In cases where family involvement is contraindicated, the agency documents the clinical or legal basis for that determination and documents regular review of the determination.

(4) The professional/clinical staff provide or locate resources most suited to the individual needs of the client in treatment foster care services and helps the client, his or her parent(s) and the treatment foster families to make effective use of them.

(5) Client's access to agency staff: An agency staff person, who is a member of the client's treatment team, is designated as a contact person for each client. The client has direct access to that staff member. The client is informed of his or her designated staff person and how to reach that person. The means for such communication is available to the client for his or her use at all times. This is documented in the client's record at admission, and each time a change is made.

(6) Crisis on call: The treatment coordinator, or another professional clinical staff member or

contractor who meets the qualifications for treatment coordinator, is on-call to treatment foster parents, client(s) and their families on a 24-hour, seven-day-per-week basis.

(7) The agency works with the local school district to access for the client the most appropriate educational services in the least restrictive setting.

(8) The agency facilitates the creation of formal and/or informal support networks for its treatment foster parents through coordination of parent support groups and/or other systems.

(9) Documentation:

(a) All contacts between agency staff and clients' biological/adoptive parents, and/or treatment foster parent(s) are documented in the client's records.

(b) All therapy notes are documented and placed in the client's record within one week of the session date.

(c) Therapy notes explicitly address the goals/objectives identified in the treatment plan.

(10) The treatment foster care services agency provides intensive support, technical assistance and supervision to all treatment foster parents. The agency trains the treatment foster family in cultural and physical care issues related to the client's race and culture prior to placement and throughout its duration, with the intention of the treatment foster family becoming culturally competent.

(11) The agency is responsible for determining that the treatment foster parent(s) effectively manage the individual treatment needs, acuity-based safety needs, and cultural needs of all clients placed in the home.

(12) The agency develops and implements a plan to connect the treatment foster client with other children and adults in the community who share the same culture, race and ethnicity.

(13) Services are provided to each client as determined by the treatment team. No one member of the treatment team has veto power except for those provision set forth in the Children's Code regarding change of placement notification. No services are terminated and/or suspended without the review and concurrence of the team. This certification requirement does not limit a managed care entity's right to determine, or the agency's or legal guardian's right to appeal, based on medical necessity criteria, the authorization of continued placement of a treatment foster care services client.

(14) The treatment plan is developed through a process that utilizes a treatment team comprised of the following individuals, as applicable and appropriate: the client, the client's family, treatment foster parent(s), treatment coordinator, department social worker, juvenile probation/parole officer, education agency, guardian ad litem and other significant individuals in the client's life.

(15) The agency ensures that all treatment plans adhere to the treatment planning requirements contained in the general provisions section of these certification requirements.

(16) The initial treatment plan includes specific tasks to be carried out by the treatment team within the first 14 days of placement.

(17) The initial and comprehensive treatment plans address strategies to ease the client's adjustment to the treatment home and to assess directly the client's strengths, skills, interests and needs for treatment within the home.

(18) The treatment plan reviews address discharge planning and strategies to prepare for the client's return to the biological, or adoptive, regular foster care home or independent living as appropriate.

(19) The treatment plan is reviewed every 30 days by the treatment team, in accordance with the general provisions, and revised when clinically indicated. The review occurs face-to-face, telephonically or through teleconference.

E. Agency oversight:

(1) Except in emergencies, a client is removed from a treatment foster care services home only after the treatment team has documented that the move is in the client's best interest. When such a move is necessary, the agency complies with pre-placement, placement and treatment planning requirements.

(2) In the event that the treatment foster parents request that a treatment foster client be removed from their home, a treatment team meeting is held and there is agreement that a move is in the best interest of the involved client. Any treatment foster parent(s) who demands removal of a treatment foster client from his or her home without first discussing with and obtaining consensus of the treatment team will have their license revoked.

(3) If treatment foster parent(s) wish to transfer between agencies, there must be written documentation from both agencies that the transfer is in the best interest of any client(s) currently in the home, including consideration of change of treatment team members, and a written statement from the previous agency that the transferring treatment foster family is in good standing.

(a) If any clients are currently placed in the transferring treatment home, the receiving agency

will evaluate the appropriateness of the match and update the treatment plan.

(b) The receiving agency completes a new home study, or an addendum to the original home study reflecting any changes that have occurred in the composition of the home since the date of the client's admission.

(c) The receiving agency notifies the previous agency that the treatment foster parent(s) has been hired, and the previous agency, upon receipt of that notice, cancels its previous license.

(4) At the time of new licensure of a treatment foster care home, if non-treatment foster care client(s) placed through prior licensing arrangements must be removed, the process is conducted through an orderly and purposeful plan which is approved in writing by the previous licensing agency as meeting the best interests of the clients.

F. Property damage and liability:

(1) Written plan: The agency providing treatment foster care services has a written policy concerning compensation for damages to a treatment foster family's property by client(s) placed in their care. A copy of the written plan is provided and explained to the prospective treatment foster parents during the pre-service training.

(2) Liability insurance: Treatment foster parent(s) document and verify on a regular basis that they continuously maintain liability insurance for automobiles, home and persons, including owner and occupants of the home.

(3) Property damage caused by client(s) in CYFD custody may be reimbursed by the protective services division of the department, consistent with protective services "maintenance payments to substitute care providers" PR 8.10.22.10.9 Property Loss and Damage.

G. Transition to independent living:

(1) Older adolescents in treatment foster care are provided with a series of developmental activities and supportive services designed to enable them to prepare to lead self-sufficient adult lives, in accord with their treatment plan. For those clients 16-20 years old for whom family reunification, placement with extended family or with previous caretakers, or adoption has been found to be infeasible or inappropriate, the agency provides or arranges for a set of service components to be delivered which are designed to enable the client to prepare for a successful transition to independent living.

(2) The services provided or coordinated address the client's identified needs for:

- (a) life skills training;
- (b) education with regard to health concerns including human sexuality;
- (c) vocational and technical training;
- (d) housing needs during transition and after discharge;
- (e) legal services;
- (f) arrangements for support services, aftercare services and socialization, and
- (g) cultural, religious and recreational activities, as appropriate to the client's needs.

[7.20.11.29 NMAC - Rp 7 NMAC 20.11.28, 03/29/02]

7.20.11.30 RESIDENTIAL TREATMENT SERVICES AND GROUP HOME SERVICES:

A. Residential treatment services are provided to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in a residential setting. They require active residential psychotherapeutic intervention and a 24-hour therapeutic group living setting to meet their developmental, psychological, social, and emotional needs.

B. Group home services are provided to children/adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, who are in need of active psychotherapeutic intervention, who require a twenty-four hour therapeutic group living setting to meet their developmental, social and emotional needs, and/or who are in transition from a higher level of care to a lower level of care.

C. The agency maintains and follows policies and procedures for emergency and non-emergency admissions. Admission policies and criteria are based on the client's identified need for residential treatment services or group home services.

D. At the time of admission or transfer to residential treatment services or group home services, the client is informed of the reasons for the placement/transfer and his/her treatment options. This discussion with the client is documented in the client's record by the admitting professional.

E. Personnel:

(1) Direct service staff providing residential treatment services and/or group home services receive a

minimum of twenty hours of pre-service training, including training in:

- (a) crisis management/intervention, behavioral management, personal restraint and seclusion;
- (b) the agency's emergency procedures, which include CPR and first aid.

(2) The direct service staff possess a high school diploma or G.E.D and one or more of the following:

(a) two years experience working with clients and adolescents with severe psychological/emotional disturbances/neurobiological disorders; or

(b) two years of post-secondary education in a human service related field; or

(c) a minimum of 40 hours of documented training, including the twenty hours of pre-service training described in E above, and twenty additional hours including the following topics:

- (i) etiology and symptoms of emotional disturbances and neurobiological disorders;
- (ii) family systems;
- (iii) basic communication and problem solving;
- (iv) child and adolescent development;
- (v) ethnic and cultural considerations related to the clients served; and
- (vi) action and potential side effects of medications.

(3) The training in (c) (i) through (vi) above, when required, must be provided within three months of hire.

(4) Those direct service staff who, prior to beginning direct service work, can provide documentation of a current certificate of training in one or more of these specified areas are not required to repeat that training; their training requirements may be adjusted as justified and documented by the clinical director or designee.

(5) Clinical director:

(a) Clinical director qualifications: The clinical director possesses one of the following New Mexico licenses: physician (physicians must be board-certified in psychiatry or eligible to attain such certification); psychologist; licensed independent social worker (LISW); clinical nurse specialist in child psychiatric nursing; registered nurse (RN) with a master's in psychiatric nursing; licensed professional clinical mental health counselor (LPCC); and licensed marriage and family therapist (LMFT);

(b) In addition to having one of the above licenses, the clinical director is required to have a minimum of two years of experience in clinical practice with clients, adolescents, and families.

(c) Clinical director responsibilities: The responsibilities of the clinical director are to provide clinical oversight of the services, as well as to provide supervision, support, and consultation to all agency staff.

(6) Clinical supervisor qualifications: The clinical supervisor possesses one of the following New Mexico licenses: physician (physicians must be board-certified in psychiatry or eligible to obtain such certification); psychologist; licensed independent social worker (LISW) or other licensed independent practitioner in a related field; clinical nurse specialist in child psychiatric nursing; registered nurse (RN) with a master's in psychiatric nursing; licensed professional clinical mental health counselor (LPCC); or licensed marriage and family therapist (LMFT). In addition to having one of the above licenses, the clinical supervisor is required to have a minimum of two years of experience in clinical practice with clients, adolescents and families.

(7) Therapists qualifications: Therapists providing individual, family and/or group therapy must meet either the necessary licensed requirements as listed for clinical supervisor or possess one of the following New Mexico licenses: licensed professional mental health counselor (LPC); licensed master's social worker (LMSW); licensed art therapist (LAT); or licensed mental health counselor (LMHC).

F. Services:

(1) Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined.

(2) The agency provides a daily structured program that meets clients' needs as identified in the comprehensive assessment and as prescribed in the treatment plan. The following services are provided:

(a) individual, family, and group therapy, at the level of frequency documented in the treatment plan;

- (b) access to timely and necessary medical care;
- (c) supervision of self-administered medication, if appropriate;
- (d) crisis intervention;
- (e) educational services;
- (f) activities of daily living;
- (g) recreation, leisure time and other planned therapeutic activities; and

(h) planning of discharge and aftercare services; to facilitate timely and appropriate post discharge care, regular assessments are conducted to support discharge planning and effect successful discharge with clinically appropriate aftercare services; this discharge planning begins when the client is admitted to residential treatment services and is updated and documented in the client's record at every treatment plan review, or more frequently as needed.

(3) The agency provides services, care, and supervision at all times, including:

- (a) the provision of, or access to, medical services on a 24-hour basis;
- (b) maintenance of a staff-to-client ratio appropriate to the level of care and needs of the

clients.

(i) for residential treatment services, the minimum ratios are one to six during the day and evening shifts and one awake staff to twelve clients during the night shift.

(ii) for group home services, the minimum ratios are one to eight during the day and evening shifts and one awake staff to twelve clients during the night shift.

(iii) additional staff must be provided if the clinical needs of the client population are high.

(iv) a written schedule must be maintained by the agency to document the staffing ratios.

(c) arrangements for, and provision of, supervision for off-grounds activities, including transportation, in accordance with minimum and need-based ratios; and

(d) arrangements for, and provision of responses to significant life events that may affect the client's treatment when out of the facility.

(4) Services and activities are appropriate to the age, behavioral, and emotional development level of the client.

(5) When not therapeutically or legally contraindicated, the agency encourages parent/client contact and makes efforts at family reunification. Such contacts and efforts are documented as they occur. If reunification is contraindicated, the reason is documented in the client's record at the time that determination is made, and the issue is reconsidered when indicated.

(6) The following factors will be considered in determining the appropriate level of services and supervision.

- (a) risk of victimizing others;
- (b) risk of inappropriate consensual activity;
- (c) risk of being victimized by others;

(7) The treatment plans contain all the elements outlined in Section 23 of these certification requirements.

G. Residential treatment services and group home services may be provided in the same licensed facility when the agency ensures the health and safety of all clients present.

(1) A program certified for residential treatment services may provide group home services in accordance with these certification requirements without requesting or receiving a separate certification for group home services.

(2) When residential treatment services and group home services are provided in the same facility, the agency's policies and procedures specify clinically-based criteria under which the populations may be mixed.

(3) When residential treatment services and group home services populations are mixed, the agency documents that the clinically-based criteria have been met to address safety issues.

(4) When residential treatment services and group home services populations are mixed, the minimum staffing ratios for residential treatment services apply.

[7.20.11.30 NMAC - Rp 7 NMAC 20.11.29, 03/29/02]

7.20.11.31 JCAHO ACCREDITED RESIDENTIAL TREATMENT SERVICES: Residential treatment services programs that are accredited by JCAHO comply with the general provisions and residential treatment services sections of these requirements, and the following standards:

A. The agency provides services, care, and supervision at all times, including maintenance of a minimum staff-to-child ratio of one to five during the day and evening shifts and one awake staff to ten clients during the night shift. Additional staff is provided when warranted by client acuity or other conditions.

B. A physical examination is completed by a licensed independent medical practitioner within one week of admission, and includes medical history, physical examination, assessment of pain, motor and sensorimotor functioning, speech, hearing, and language functioning, vision, immunizations, oral health, history of psychotropic

medication use, and, when indicated an AIMS test. If a comprehensive medical history and physical examination have been completed within 30 days before admission, a durable, legible copy of this report may be used in the clinical record as a physical examination, but any subsequent changes must be recorded at the time of admission.

C. The agency evaluates the need for the following assessments, and when such assessments are indicated, they are completed in a thorough and timely manner: psychological, psychiatric, educational, vocational, legal, nutritional, developmental disabilities, and substance abuse.

D. The agency has a written plan to provide all necessary medical histories, physical examinations, and laboratory tests that the agency does not directly provide.

E. Infection control

(1) The agency has a comprehensive and functioning infection-control program based on proven epidemiological methods for surveillance and prevention of adverse outcomes related to infection.

(2) The agency uses preventive processes such as universal precautions to reduce risks for endemic and epidemic infections in clients and staff.

(3) Infection control policies, procedures, and practices include surveillance, identification, and control of infection, and required reporting to staff and public health authorities.

(4) A current certification stating that the employee is free from tuberculosis in a transmissible form, obtained prior to the first date of direct service.

[7.20.11.31 NMAC - Rp 7 NMAC 20.11.30, 03/29/02; A, 10/29/04]

7.20.11.32 [Reserved]

[7.20.11.32 NMAC - N, 03/29/02; Repealed 04/14/05]

7.20.11.33 COMPREHENSIVE COMMUNITY SUPPORT SERVICES:

A. Agencies certified for case management under these regulations or agencies receiving children's behavioral health contract funding for case management services as of 01/01/08 will receive provisional certification as a comprehensive community support services provider.

B. The provisional certification will be valid until the expiration of the agencies case management certification at which time a survey will be completed by the licensing and certification authority. Children's behavioral health contract agencies will have a survey completed within twelve (12) months of the issuance of the provisional certification.

C. All comprehensive community support services providers will have to meet the general provisions of these requirements and requirements in medicaid regulation Title 8, Chapter 315, Part 6.

[7.20.11.33 NMAC - N, 01/01/08]

HISTORY OF 7.20.11 NMAC:

Pre-NMAC Filing History:

OMCI, Purpose and Definitions Relating to Certification Regulations, 11-23-93.

A.O., Agency in the Community, 11-23-93.

B.O., Agency Governance and Administration, 11-23-93.

C.O., Personnel, 11-23-93.

D.O., Client Rights and Protection, 11-23-93.

H.O., Intake, Assessment and Treatment Planning, 11-23-93;

I.O., Client Information, Confidentiality and Case Review, 11-23-93.

AA.O., Group Home Services, 11-23-93.

BB.O., Residential Treatment Centers, 11-23-93.

DD.O., Treatment Foster Care, 11-23-93.

EE.O., Day Treatment Centers, 11-23-93.

GG.O., Behavior Management Skills Development Services, 8-16-94.

NMAC History:

7 NMAC 20.11, Certification Requirements for Child and Adolescent Mental Health Services, 6-16-98.

7 NMAC 20.11, Certification Requirements for Child and Adolescent Mental Health Services, 10-27-99.

History of Repealed Material:

7 NMAC 20.1, General Provisions - Repealed 7-1-98.

7 NMAC 20.A, Agency in The Community - Repealed 7-1-98.
7 NMAC 20.B, Agency Governance and Administration - Repealed 7-1-98.
7 NMAC 20.C; Personnel - Repealed 7-1-98.
7 NMAC 20.D, Quality Assurance and Utilization Review - Repealed 7-1-98.
7 NMAC 20.E, Regulatory Compliance for Program Operation Including Health, Safety and Physical Plant Requirements - Repealed 7-1-98.
7 NMAC 20.F, Client Rights and Protection - Repealed 7-1-98.
7 NMAC 20.G, Intake, Assessment and Treatment Planning - Repealed 7-1-98.
7 NMAC 20.H, Client Information, Confidentiality and Case Review - Repealed 7-1-98.
7 NMAC 20.AA, Case Management - Repealed 7-1-98.
7 NMAC 20.BB, Day Treatment - Repealed 7-1-98.
7 NMAC 20.CC, Behavior Management Skills Development Services - Repealed 7-1-98.
7 NMAC 20.DD, Treatment Foster Care - Repealed 7-1-98.
7 NMAC 20.EE, Residential Treatment Centers - Repealed 7-1-98.
7 NMAC 20.11, Certification Requirements for Child and Adolescent Mental Health Services - Repealed, 11-15-99.
7 NMAC 20.11, Certification Requirements for Child and Adolescent Mental Health Services - Repealed, 3-29-02
7.20.11 NMAC, Section 32, Home-Based Services - Repealed 04-15-05