MINNESOTA OUTPATIENT PROCEDURE

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Family & Children's Center

Procedure Name:	ADMISSIONS PROCESS
Procedure Number:	101
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Admission Paperwork Procedure 103

STATEMENT OF PURPOSE

Family & Children's Center serves children, adolescents, adults and families in the outpatient clinic. Clients may request the services themselves or be referred by an outside agent (physician, attorney, etc.). The admission criteria procedure details the protocol for outpatient admission and outlines steps to refer clients to alternative services when needed.

AREAS OF RESPONSIBILITY

Administrative Assistants maintain positive relationships to ensure that all clients, referral sources, and staff are receiving the highest quality services in a manner consistent with FCC's mission, vision, and values. Administrative Assistants maintain client files by obtaining, recording and updating personal and financial information in accordance with agency policies and governing standards. They must adhere to all laws of client rights, confidentiality and privacy as governed by HIPPA, governing standards, and FCC.

PROCEDURE

I. Initial Contact
   a. It is necessary to determine the type of service a client is seeking and with which provider to schedule.
   b. Complete a telephone intake sheet with necessary demographic information including personal and identifying information. The intake sheet also includes emergency health needs and safety concerns.
   c. Obtain the client's insurance information so the revenue cycle department can ensure FCC is in network.
   d. The revenue cycle department will verify insurance benefits including client deductible, coinsurance, out-of-pocket maximum, and prior authorization requirements.
   e. The revenue cycle department will check Procentive to see if the client is already in the system.

        i. If client is in Procentive and has a past due balance, it is necessary to get payment in full or set up a payment plan prior to client resuming services.
        ii. If client is not in Procentive, the revenue cycle department will enter their information in the system.

II. Scheduling
   a. After insurance verification is complete, the client needs to be contacted to schedule an intake appointment.
        i. When scheduling, follow the individual provider's scheduling preferences (i.e., how many intakes per week, time of day, etc.)
   b. Give client appointment time that ensures enough time to complete paperwork prior to meeting with provider (usually ½ hour prior).
   c. If provider has a waiting list or is scheduling out several weeks, schedule additional appointments for the client at this time.
   d. Prior to the client coming into appointment, verify that all intake documents have been entered into Procentive. Please refer to Admission Paperwork Procedure 103 for a list of necessary documents.

III. Intake Appointments
   a. Review required intake forms with client and have them sign electronically or complete paper forms then scan into client's Procentive account.
   b. Get a copy of the front and back of the client's insurance card and scan into their Procentive account.
   c. Collect any applicable copays.
   d. Verify insurance and demographic information provided by client to ensure information is entered correctly into Procentive.
   e. Give provider the copy of any paper forms (questionnaire, intake sheet, etc.)

IV. Subsequent Appointments
   a. At every visit, verify client's address, phone number, and insurance information and ensure it is correct in Procentive.
   b. Check account balance and discuss making a payment or setting-up a payment plan with client, if necessary.
   c. Collect any applicable copays.

V. Appointment cancellation
   a. Any appointment that a client requests to cancel or reschedule less than 24 hours prior to the appointment will be documented as a "Late Cancel" in Procentive.
   b. If a client fails to attend an appointment, it will be documented as a "No Show" in Procentive.

GETTING HELP

For questions or further clarifications regarding the admissions process, please contact the Winona Administrative Assistant or the Coordinator of Community Services.

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Procedure Name:	ADMISSIONS CRITERIA
Procedure Number:	102
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Edited by: Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

Family & Children's Center serves children, adolescents, adults and families in the outpatient clinic. Clients may request the services themselves or be referred by an outside agent (physician, attorney, etc.) The admission criteria procedure details the protocol for outpatient admission and outlines steps to refer clients to alternative services when needed.

AREAS OF RESPONSIBILITY

Admissions criteria may first be communicated to the client by the Administrative Assistant. Outpatient providers are responsible for determining level of care and appropriate services. It is the responsibility of the outpatient providers to review with the client the needs of the client and how well the organization can meet those needs, what services are available and when are those services available, and the rules and expectations of the program.

PROCEDURE

Clients

Family & Children's Center serves children, adolescents, adults, couples and families in the Outpatient Clinic. Clients will be scheduled with the appropriate provider based on their expertise. Family & Children's Center provides equitable services for all, gives priority to clients with urgent needs, identifies children and families with co-occurring needs and facilitates assistance for them, provides access to a comprehensive assessment process, and gives timely initiation of services.

Funding

There must be a funding source for services, including private insurance, medical assistance, or private pay. Some insurance companies and Minnesota medical assistance restrict where enrollees may go for services. Within these constraints, the outpatient program does not deny its services or discriminate against, on the basis of sex, race, color, creed, handicap, age, sexual orientation, cultural background, or location.

Admission

Should there be a waiting list for services, clients will be contacted and served on a first-come, first-served basis. The Administrative Assistant will maintain a waiting list that includes the client's contact information and the date of the initial referral. The waiting list information will be communicated to the Community Services Coordinator on a weekly basis.

Referral

Clients whom do not meet the admission criteria or cannot be served promptly are referred or connected to appropriate providers. Contracts are kept on file with local service providers and updated every two years. The Administrative Assistant maintains the referral list.

Several agencies on the referral list include:
Winona Health, Hiawatha Valley Mental Health Center, Common Ground, Legacies, Winona Counseling services, Winona County Human Services or other appropriate mental health service.

GETTING HELP

Support for admission procedures can be obtained by connecting with your Clinical or Administrative Supervisor.

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Procedure Name:	ADMISSIONS PAPERWORK
Procedure Number:	103
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalenksy, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	F244-1000 Authorization for Use & Disclosure of Health Information, F244-1001 Notice of Privacy Practices Written Acknowledgment Receipt, F244-1002 Statement of Rights and Responsibilities, F244-1007 Consent for Admission for Outpatient Mental Health/Substance Abuse Evaluation, F244-1004 Consent for Counselor in Training, F244-1010 Payment Agreement for Counseling Services Including copy of Insurance Card or verification of benefits, F244-1013 Post-discharge Research Consent, F244-1000 Authorization for Use & Disclosure of Health Information, F244-0006 Referral Source- Client Intake

STATEMENT OF PURPOSE

Family & Children's Center will inform clients of their rights, notify clients of confidentiality both verbally and in writing, and have clients sign consents to treatment of services.

AREAS OF RESPONSIBILITY

Admissions paperwork will be completed with the Administrative Assistant upon first visit to the clinic, and updated annually. Providers are responsible for determining level of care and appropriate services, and notifying clients of their treatment rights.

PROCEDURE

Initial Intake Paperwork: The client or parent/guardian completes the admissions paperwork at the desk prior to first appointment with the provider, and annually thereafter. Paperwork is completed on the tablet or in paper form then scanned in to Procentive by the Administrative Assistant. The Administrative Assistant explains each form and fees that the client or responsible party will be expected to pay for the proposed services. Each identified client has their own record and admissions paperwork.

Clients are to complete the following forms upon admissions:

Outpatient Client-

1. F244-1007 Consent for Admission for Outpatient Mental Health/Substance Abuse Evaluation
2. F244-1001 Notice of Privacy Practices Written Acknowledgment Receipt
3. F244-1002 Statement of Rights and Responsibilities

4. F244-1004 Consent for Counselor in Training – if applicable
5. F244-1010 Payment Agreement for Counseling Services (Including copy of Insurance Card or verification of benefits)
6. F244-1013 Post-Discharge Research Consent
7. F244-1000 Authorization for Use & Disclosure of Health Information as needed
8. F244-1033 Permission for Communication
9. F244-0006 Referral Source- Client Intake
10. PRO-1503 WHODAS 12-item Proxy-Administered for children
11. PRO-1500 WHODAS 36-item Self-Administered for adults

Client needs to complete following paper forms:

Adults

1. DSM 5 Level 1 Cross-Cutting Symptom Measure (www.psychiatry.org)
2. Adult DA bio-psych-social intake

Adolescents

1. SDQ (both self-administered (S^{11-17}) and parent versions (P^{11-17})
2. Pre DA Adolescent Survey

Children

1. SDQ ($P^{3-4,}$ P^{4-10})
2. Pre DA Parent Survey

On-going Informed Consent

1. Families are informed and sign written consent (F244-1000 Authorization for Use & Disclosure of Health Information) every time information is to be shared or requested with a new external source.

GETTING HELP

Support for admission paperwork can be obtained by connecting with your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	EMERGENCY SERVICES
Procedure Number:	104
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Services
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Services
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	F244-1002 Statement of Rights and Responsibilities

STATEMENT OF PURPOSE

Any individual who receives outpatient mental health services may experience a mental health crisis at any time during their treatment. Family & Children's Center is obligated to provide emergency services information to ensure clients have access to care in times of crisis.

AREAS OF RESPONSIBILITY

As a certified outpatient mental health facility, the Family & Children's Center is obligated to provide 24-hour emergency services to its outpatient clients. (Procedures are outlined in the Statement of Rights and Responsibilities under the heading "Emergency Procedures").

The Administrative Assistant handles all calls received during desk hours, after hours the callers are directed to call Winona County Crisis Response line at 1-844-274-7472, 911, or the Emergency Room at Winona Health if they are seeking help with a crisis situation.

The Administrative Assistant, in collaboration with the client's provider, may direct a client to emergency services over the phone when appropriate. Outpatient providers are responsible for providing and discussing emergency calls with clients and providing after hour contacts in the intake session. Any crisis contacts should be documented in the clients file.

PROCEDURE

Immediate Crisis during Office Hours

1. Does a provider at Family & Children's Center know the client?
   If yes, continue.
   If no, go to #4.
2. Is the provider at Family & Children's Center at this moment?
   If yes, continue.
   If no, go to #4.
3. The Administrative Assistant contacts the provider; is the provider able to speak to the client?
   If yes, put the client through to the provider.
   If no, go to #4.

4. Refer the client to one of the following:

Emergency	911
Great Rivers 211	211 or (800) 362-8255
Winona Health ER	(507) 454- 3650
Crisis Response Line	(844) 274-7472
National Suicide Talk Line	(800)-273-8255
Tri-State Suicide Crisis Line	(800)-362-8255

Immediate Crisis after Office Hours

Voicemails will be recorded directing clients to call 911 in case of an emergency.
and to one of the following:

Emergency	911
Great Rivers 211	211 or (800) 362-8255
Winona Health	(507) 454-3650
Gundersen Health System	(608) 775-3128
Winona County Crisis Response	(844)-274-7472
Mayo Clinic Health System ER	(608) 392-7000
National Suicide Talk Line	(800)-273-8255
Tri-State Suicide Crisis Line	(800)-362-8255

Medication Reaction or Need during Office Hours

Refer client to family physician, psychiatrist or the walk-in clinics at Winona Health. In case of an emergency, call 911.

Medication Reaction or Need after Office Hours

Refer client to Winona Health. In case of an emergency, call 911.

GETTING HELP

Support for emergency calls can be obtained by connecting with your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	CLIENT RECORDS
Procedure Number:	105
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Electronic health Records Policy, Electronic Health Records User and Confidentiality Agreement

STATEMENT OF PURPOSE

Case records provide critical details about clients' dispositions and can demonstrate thorough clinical assessment and informed consent. Family & Children's Center (FCC) recognizes the need to protect the security, confidentiality, integrity and availability of our clients' information and to do so in accordance with the HIPAA Security Rule and other federal and state regulations. In addition, information used in the course of FCC's business is a vital asset that enhances continuum of care to clients and requires protection from unauthorized access, modification, disclosure or destruction.

AREAS OF RESPONSIBILITY

Both providers and Administrative Assistants contribute to case records. Records are also subject to internal and external review to ensure licensing and accreditation compliance. Client records are stored through Procentive, an Electronic Health Record (EHR) program. Paper records are maintained by the Administrative Assistant.

PROCEDURE

All of Family & Children's Center Staff and Electronic Health Users will read, sign and comply with the Electronic Health Records Policy and Electronic Health Records User and Confidentiality Agreement before having access to the EHR system.

Individual Case Records:

There must be a client file for every client that is seen at Family & Children's Center. Outpatient case records are kept electronically. Providers may not keep client files in their homes. It is the responsibility of providers to make sure the records of their clients are available at the beginning of each business day and throughout the day as needed. It is the responsibility of the providers and Administrative Assistants to ensure that confidentiality and safety of records are maintained at all times.

It is the policy of FCC that records generated in one department are not shared with staff outside that department without a written release form signed by the client.

Records released to outside agencies when the client has signed a release form include: treatment plan, assessment, and diagnostic assessments (unless otherwise specified by client). Progress notes are not released unless specifically requested by the client.

In Minnesota, client clinical records in paper form are kept on file for at least ten (10) years from the date of discharge, or until the client reaches the age of 25, whichever is greater. In the event that the Winona outpatient program closes, records will be stored in the secure storage area at FCC's main location: 1707 Main Street, La Crosse, WI. Client clinical records via electronic health system will be stored within that database for a minimum of at least ten (10) years from the date of discharge or until the client reaches the age of 25, whichever is greater.

Upon termination of a provider, the client clinical records for which they are responsible shall remain in the custody of the clinic where the client was receiving services unless the client requests in writing that the records be transferred.

GETTING HELP

Support for client records can be obtained by connecting with your Clinical or Administrative Supervisor, or Quality Improvement Coordinator.

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Family & Children's Center

Procedure Name:	ASSESSMENT PROCEDURES
Procedure Number:	201
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Hood, A.B & Johnson, R.W. (2007). Assessment in counseling: A guide to the use of psychological assessment procedures. Alexandria, VA: American Counseling Association. F244-1000 Outpatient-WI-Diagnostic Assessment, MV 3634 Order for Assessment and Driver Safety Plan Report

STATEMENT OF PURPOSE

"Psychological assessment is an integral part of counseling…Assessment serves the following functions: (a) to stimulate counselors and clients to consider various issues, (b) to clarify the nature of a problem or issue, (c) to suggest alternative solutions for problems, (d) to provide a method of comparing various alternatives so that a decision can be made or confirmed, and (e) to enable counselors and clients to evaluate the effectiveness of a particular solution (Hood & Johnson, 2007, p.11).

AREAS OF RESPONSIBILITY

Providers are responsible for providing a diagnostic assessment and selecting additional assessments and screenings that meet the individual needs of their clients. Providers are responsible for utilizing the information to diagnose a mental illness and support the clients' understanding of their functioning. The assessment is a strength-based process that is directed towards concerns that were identified at intake and that address any issues of special relevance. Providers may refer clients for further or more specialized assessment. Providers can also make recommendations or provide feedback about assessments during peer supervision at case consultation.

Providers gather data from clients or others (family members, teachers, friends, caseworker, etc.). Assessment methods include standardized tests, rating scales, projective techniques, behavioral observations, biographical measures, and physiological measures. The material obtained is limited to that which is pertinent to accomplishing their treatment goals.

PROCEDURE

For mental health services, a diagnostic assessment is completed before the fourth visit. The initial assessments can be completed using structured/semi-structured clinical interviews, assessments, admissions paperwork and collateral interviews (with appropriate releases). This assessment of a client shall accurately reflect the client's current needs, strengths and functioning. The assessment needs to be done in a culturally

and linguistically appropriate way and identify resources that can increase client participation and goal achievement.
The mental health professional or clinical trainee working with the client on an assessment will engage with the client in the following ways;

- Be sensitive to the willingness of the client to be engaged
- Present the assessment in a non-threatening manner
- Respect the client's autonomy and confidentiality
- Be flexible and persistent with the client to reach assessment goals

When a client is referred by another agency, the assessment may be abbreviated to this extent: assessment information need not be obtained again if written information sent by the referring agency is current and includes all of the information below. The provider need only obtain information that is not available in the written assessment provided by the referring agency. However, the accuracy of the referral information should be corroborated briefly with the client.

Mental health assessment:
F244-1000 Outpatient-MN- Diagnostic Assessment

1. Clients life situation; age, living situation, basic needs and economic status, education and employment status, significant personal relationships, strengths and resources, belief systems, contextual non-personal factors, general physical health, legal history, current medications

2. The client's presenting problem(s) and symptoms and reason for referral; perception of condition, symptoms, reason for referral, history of mental health and treatment, important developmental incidents, trauma history, maltreatment or abuse, history of alcohol and drug abuse and treatment, health history, family health history, cultural influences

3. Risk Assessment; risk of self-harm or suicide, current risk of harm to self or others, neglect, and exploitation

4. Mental status exam

5. Support for ED or SED diagnosis

6. Intervention needs

7. Screenings; Kiddie-CAGE or CAGE AID,

8. Functional Assessments; SDQ, CASII

9. Assessment and tools; Comprehensive Longitudinal Assessment, Contextual Assessment, other assessment tools including trauma screening and suicide risk assessment when applicable
10. Client needs: including social supper service needs
11. Clinical Summary; recommendation and prioritization of needed mental health service including client and family participation is assessment and service preferences
12. Provisional Diagnostic Hypothesis
13. A diagnosis, which shall be established from the current Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5), or for children up to age 4, the current Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Providers can also refer to the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
14. Supportive assessments
15. Problem areas as identified by the assessment; these will be addressed in the individual treatment plan
16. Specific service recommendations
17. Referral contact information
18. Medical necessity

Assessment findings:
If a client is determined to have one or more co-occurring disorders, a provider shall document the treatments and services concurrently received by the client from other providers, if the client will be provided treatment or referred, and any additional recommendations.

If treatment is not recommended for a client after the assessment, the reasons for this will be documented in the case record along with the recommended course of action for the client.

At the time of assessment when it is determined treatment is recommended the client is informed of the following:

1. Treatment alternatives.

2. Possible outcomes and side effects of treatment recommended in the treatment plan.
3. Treatment recommendations and benefits of the treatment recommendations.
4. Approximate duration and desired outcome of treatment recommended in the treatment plan.
5. The rights of a client receiving outpatient mental health services, including the client's rights and responsibilities in the development and implementation of an individual treatment plan.
6. The outpatient services that will be offered under the treatment plan.

If during the assessment there are unmet medical needs that are identified the provider would refer the client to Winona Health or a medical center of the client's choice so their needs can be addressed. These unmet medical needs can include:

- Medication monitoring and management
- Physical examinations or physical health concerns
- Medical detoxification
- Laboratory testing and toxicology screens
- Other necessary diagnostic procedures

Reassessments:

Reassessments will be conducted as necessary and are done according to the needs of the recipient. For children, the reassessment must be done annually following the initial assessment if continuation of services is deemed necessary, and/or when the child's mental health condition has changed markedly from their last diagnostic assessment, and/or when the child's current mental health condition or symptoms do not match their current diagnosis. For adults, reassessment must be done every three years if continuation of services is deemed necessary, and/or when the adult's mental health condition has changed markedly from their last diagnostic assessment, and/or when the adult's current mental health condition or symptoms do not match their current diagnosis.

Assessment and screening tools:

The Outpatient department has paper assessments and screenings available. This includes, but is not limited to, marital evaluation checklist, Children's Inventory of Anger and MMPI-2. Additional assessments and screenings are built into EHR. Be advised that assessments and screenings have different requirements; please review all requirements prior to administering assessments and screenings.

Assessments can be ordered if approved by Administrative Supervisor.

GETTING HELP

Support for admission procedures can be obtained by connecting with your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	RISK ASSESSMENT
Procedure Number:	202
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	F244-1102 Outpatient Suicide Risk Assessment, F244-1008 Outpatient- Plan for Safety and Continuity of Care Hood, A.B & Johnson, R.W. (2007). *Assessment in counseling: A guide to the use of psychological assessment procedures.* Alexandria, VA: American Counseling Association

STATEMENT OF PURPOSE

"Psychological assessment is an integral part of counseling….. Assessment serves the following functions: (a) to stimulate counselors and clients to consider various issues, (b) to clarify the nature of a problem or issue, (c) to suggest alternative solutions for problems, (d) to provide a method of comparing various alternatives so that a decision can be made or confirmed, and (e) to enable counselors and clients to evaluate the effectiveness of a particular solution" (Hood & Johnson, 2007, p.11).

AREAS OF RESPONSIBILITY

Providers are responsible for risk assessment during diagnostic assessment and throughout treatment.

PROCEDURE

During each session with the client, the provider will assess and document risk or harm to self or others, suicidal and/or homicidal ideation, planning, and intent in the clients file. Form F244-1102 Outpatient Suicide Risk Assessment is available in EHR.

For ideation, the provider will verbally contract with the client regarding contacting emergency services or the local crisis line if a plan or intent develops. Verbal contract will be documented in the client's records

In cases where a plan and/or intent are also present, the provider will assess the client using the risk assessment.

If threat is deemed mild to moderate, the provider will develop a safety plan (F244-1008 Outpatient- Plan for Safety and Continuity of Care form available in EHR) with the client. The plan will be signed by client and provider and placed in the client's record. If threat is deemed moderate to severe, the provider will do one of the following:

1. Call the local crisis line. Provider will discuss the situation with the crisis worker and work with the client to develop a safety plan. The plan will be documented and the client will be asked to sign their consent to follow the plan. The plan will then be implemented.
2. Arrange for a friend or family member to take the client to the local emergency department. The provider may call for a police escort if deemed necessary.
3. Obtain agreement from client to go directly to the local emergency department and call for a police escort.

If the client will not agree to go willingly to either the emergency department, call police to arrange for transport. This is the last resort.

The mental health provider will obtain necessary release(s) from the client to consult with or inform others as required by law and whenever practical.

The contacts made and the actions taken will be noted in the client's record.

GETTING HELP

Support for admission procedures can be obtained by connecting with your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	ETHICAL DECISION MAKING MODEL
Procedure Number:	203
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Alicia Skiles, MS, NCC
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Fossen, C. M., Andersen-Meger, J.I. & Daehn-Zellmer, D. A. (2014). Infusing a new ethical decision-making model throughout a BSW curriculum. Journal of Social Work Values and Ethics, 11(1) 66-81. (based on the Model by E.P. Congress)

STATEMENT OF PURPOSE

Ethical decision-making is critical when a professional needs to address a conflict or evaluate uncertainty about competing values. Most professions have a code of ethics that guide professionals in this process. The following procedure is an ethical decision making model that can aid in processing and documenting ethical decision-making.

AREAS OF RESPONSIBILITY

Providers and administrators are responsible for following the code of ethics for their respective professions and for applying an ethical decision making model when indicated.

PROCEDURE

E T H I CS-A Model (Fossen, Andersen-Meger & Zellmer, 2014)

1. Examine issue and dilemma. Examine the situation—determine if this is an ethical dilemma. Examine values—personal, societal, agency, client and professional values.

2. Think about values--personal, societal, cultural, agency, client and professional. Think about ethical issues, principles, standard laws or policies that apply to this ethical dilemma.

3. Hypothesize possible scenarios and consequences of different decisions including the role of advocate. Hypothesize all possible decisions or options. Identify who will benefit or be harmed with a commitment to the most vulnerable.

4. Identify consequences of each possible decision or option.

5. Consult with supervisor and colleagues about possible ethical choices. Consult with supervisor and colleagues about ethical choices.

6. Select decision or ethical action and get support.

7. Advocate within agency, social work community, local, state and national. Advocate for change on appropriate system level. Document both decision-

making process and ethical decision. Legal scan: is the process and decision ordinary, reasonable, and prudent?

GETTING HELP

Support for ethical decision-making can be obtained by connecting with your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure name:	PHILOSOPHY & INTERVENTIONS
Procedure Number:	301
Domain:	Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

Family & Children's Center promotes service modalities and interventions that respect diversity and promote individual wellbeing.

AREAS OF RESPONSIBILITY

Providers and staff work together to ensure effective interventions and continuity of care.

Philosophy of Care

Family & Children's Center Outpatient clinic focuses on personalized mental health treatment for children, adults and families seeking support to strengthen families and improve their well-being. We provide holistic services and care that incorporates clinical therapy and interactive modalities adjusted to meet the individual needs of the client. The services are provided in a culturally and linguistically responsive manner. Our Philosophy of Care is grounded in several key components that are embedded in our work and our agency operations.

- Respecting and affirming diversity
- Trauma informed care
- The use of harm reduction principles when appropriate
- Strength based models of relationship building to promote community and family stability
- Systems approach addressing unique individual needs of the client in a collection of diverse relationships and experiences.

Procedure

Treatment

Family & Children's Center provides therapeutic and educational interventions that include individual, family, or group modalities. Each of these interventions is based on research and clinical practice guidelines. Each intervention is matched with the client's needs, age, developmental level, and personal goals. Clients receive goal directed psychosocial treatments including psychotherapy, psychoeducation interventions, medication education, coping skills training, relapse prevention, and support groups and

self-help referrals. Clients and families are also connected to peer support networks, as appropriate. If Family & Children's Center cannot meet all the needs of the client, a referral is made to outside sources to ensure a comprehensive range of prevention and treatment services, including acute care.

Non Standard Treatment

When non-traditional or unconventional practices are recommended/used, Family & Children's Center must obtain the informed consent of the client, or, in the case of a minor, of the client's family/legal guardian. The case must also be reviewed at the PQI quarterly meeting.

If non-traditional or unconventional interventions are permitted, providers should:

a. explain the risks and benefits

b. explain treatment alternatives

c. ensure proper qualification or certifications have been met to provider service

d. monitor and document use and effectiveness.

Any intervention should be discontinued if it produces adverse side effects or is deemed unacceptable according to prevailing professional standards.

Prohibited Interventions

Providers are prohibited from using the following in any capacity of their practice:

1. corporal punishment
2. aversive stimuli
3. interventions that involve withholding nutrition or hydration or that inflict physical or psychological pain
4. demeaning, shaming or degrading language or activities
5. forced physical exercise to eliminate behaviors
6. unwarranted use of invasive procedures or activities of disciplinary action
7. punitive work assignments
8. punishment by peers
9. group punishment or discipline for individual behaviors.

GETTING HELP

Support for services provided can be obtained by connecting with your Clinical or Administrative Supervisor.

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Procedure Name:	TREATMENT APPROACHES
Procedure Number:	302
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

Family & Children's Center providers utilize a variety of therapy approaches that are selected based on the unique needs of their clients. Through ongoing training, clinical supervision, consultation and clinical collaboration, providers are able to utilize a variety of approaches to benefit the variety of clients seeking services in our outpatient clinic.

AREAS OF RESPONSIBILITY

Providers and staff work together to ensure effective interventions and continuity of care.

SERVICES PROVIDED

1. Initial assessment of new clients.
2. Diagnostic services to classify a client's problem.
3. Evaluation services to determine the extent to which the client's problem interferes with normal functioning.
4. Outpatient mental health services as defined as Psychotherapy Service Minnesota Statutes 9505.0372.

PROCEDURE

<u>Outpatient Counseling Services</u>

Counseling Services:

1. Manage mental health disorders;
2. cultivate and sustain relationships with peers, families, and the community;
3. develop self-efficacy; and
4. promote whole person wellness.

Providers and staff engage and motivate individuals and families by demonstrating:

1. Sensitivity to the needs and personal goals of the service recipient;
2. a non-threatening manner;
3. respect for the person's autonomy, confidentiality, socio-cultural values, personal goals, self-expression, and complex family interactions;
4. flexibility; and

5. appropriate boundaries.

Therapeutic and educational interventions may include individual, family, or group therapy and self-help referrals and are:

1. Based on research or clinical practice guidelines where they exist; and
2. matched with the assessed needs, age, developmental level, and personal goals of the service recipient.

Providers assist clients to:

1. Explore and clarify the concern or issue;
2. voice the goals she or he wishes to achieve;
3. identify successful coping or problem-solving strategies based on the individual's strengths, formal and informal supports, and preferred solutions; and
4. realize ways of maintaining and generalizing the individual's gains.

If a client is a trauma survivor or a victim of violence, abuse or neglect, FCC provides:

1. A protection or safety plan, as needed;
2. more intensive services;
3. trauma-informed care;
4. more frequent monitoring of progress toward treatment goals; and
5. a referral when appropriate.

Providers:

1. Determine the optimal level of intensity of care, including clinical and community supports;
2. follow up when an evaluation for psychotropic medications and medication-assisted treatment is recommended;
3. use written criteria for determining when the involvement of a psychiatrist is indicated; and
4. coordinate care with other service providers, with the consent of the client.

Couples and/or Family Therapy

When a client's presenting problem affects or is affected by a client's family, other family members are offered services or are included in the service planning with the informed consent of the client, or, in the case of a minor client, the parent or legal guardian. When a provider is seeing a couple or more than one family member, each person must provide written consent for treatment and receive rights notification.

Group Therapy

Group therapy sessions for mental health must not exceed 12 clients and two therapists, with a minimum staff to client ratio of 1 to 8.

Care Coordination

As a part of the service recipients treatment the Family & Children's Center coordinates with other caregivers involved in the client's treatment. Providers work with the client to find out any barriers that the individual may have to receive the coordinated services. Individuals with a co-occurring mental health and substance use disorder receive coordinated care through treatment from the Family & Children's Center and the outside agency. Other agencies and systems that the Family and Children's Center coordinates with as needed are the child welfare system, the juvenile justice system, the courts, and the school system to provide holistic care for the individual. All the activities of care coordination are documented in the client's record including any collateral contacts made with internal and external service providers, follow-up to referrals as needed, and communication with the service recipient and/or family.

GETTING HELP

Support for clinical counseling services can be obtained by connecting with your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure name:	SUPPORT SERVICES
Procedure Number:	303
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

Family & Children's Center promotes working with community supports in order to address each individual as a whole person. The purpose of this procedure is to list community supports and contact information to be used as a reference for all staff.

AREAS OF RESPONSIBILITY

Providers and staff work together to ensure that community support options are given to clients so we can provide an individualistic and holistic approach to each person we serve. Providers and staff work with the service recipient to identify natural supports and social networks to cultivate and sustain a supportive community. In addition, if the provider and/or staff work with a service recipient who has primary responsibility for children, the staff work with the client to ensure they receive accommodations for, or assistance with, childcare arrangements so that this is not a barrier to treatment.

PHILOSOPHY OF CARE

Family & Children's Center Outpatient Clinic focuses on personalized treatment for children, adults and families seeking support to strengthen families and improve their well-being. We provide holistic services and care that incorporates community support services for the individual in need.

PROCEDURE

Community Supports

Family & Children's Center staff can refer clients to outside agencies to ensure each individual is getting the care and help that they need in order to be successful. Below is a list of community support services that can be utilized to aid our clients:

- **Work**
  ORC –
    Toll-free Phone: 800-657-4846
    Phone: 507-452-1855
    Fax: 507-452-1857

Workforce Center –
Phone: 507-205-6060

- **Supported Housing**
  Hiawatha Valley Mental Health Center Board and Lodge –
  Toll-Free Phone: 800-657-6777
  Phone: 507-454-4341
  Fax: 507-453-6267
  Dan Corchan House –
  Phone: 507-454-8094
- **Support Groups**
  Alcoholics Anonymous –
  Phone: 507-452-2348
  Narcotics Anonymous –
  Phone: 877-767-7676
  NAMI –
  Phone: 507-494-0905
  Peer Support Network –
  Toll-Free Phone: 800-657-6777
  Phone: 507-454-4341
  Fax: 507-453-6267
- **Public Benefits**
  Winona County Community Services –
  Phone: 507-457-6200
  Catholic Charities –
  Phone: 507-454-2270
- **Food Resources**
  Winona Area Public Schools Ford Resource List -
  http://www.winona.k12.mn.us/sites/winonaaps.new.rschooltoday.com/files/files/Private_User/ljacobs/Winona%20Additional%20Food%20Resources%202016.docx
  Winona County Community Resources-
  Phone: 507-457-6200
- **Educational Benefits**
  ECFE –
  Phone: 507-494-0913
  Early Childhood Hopeline:
  Phone: 507- 429-4471
- **Social Skills Training/Therapy**

Hiawatha Valley Mental Health Center –
Toll-Free Phone: 800-657-6777
Phone: 507-454-4341
Fax: 507-453-6267
Catholic Charities –
Phone: 507-454-2270
Counseling Associates, LLC –
Phone: 507-452-5033
Fax: 507-452-5183
Peace of Mind Counseling –
Phone: 608-797-5679
Athena Counseling –
Phone: 507-474-4140
Winona Equine Therapy thru Counseling Associates –
Phone: 507-452-5033
Fax: 507-452-5183

- **Transportation**
  Semcac –
  Phone: 507-452-8396
  Fax: 507-457-0564
- **Respite Care**
  Winona County Community Services –
  Phone: 507-457-6200
- **Child Care**
  Child Care Assistance Program Winona County –
  Phone: 507-529-4637

GETTING HELP

Support for services provided can be obtained by connecting with your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	SUPERVISION
Procedure Number:	304
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	DHS-6330, MN OP 401:Qualifications Procedure

STATEMENT OF PURPOSE

The purpose of clinical supervision, consultation and clinical collaboration is to support staff and to monitor the quality of services provided. Clinical supervision, consultation and clinical collaboration is conducted in a manner that satisfies the requirements of the State, the Council on Accreditation (COA), and other professional organizations with which the agency is affiliated.

AREAS OF RESPONSIBILITY

Any provider who provides services to clients will participate in clinical consultation and collaboration to support staff and monitor the quality of services provided. Clinical supervision will be provided for clinical trainees.

PROCEDURE

Clinical Supervision

Clinical supervision is defined in DHS Minnesota Statutes 254.462 as "the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities." Part of the supervision process is to determine workloads for providers which is based on the qualifications of the provider along with their competencies and experience. The time to accomplish assigned tasks and job responsibilities and service volume also need to be taken into consideration.

Clinical supervision is based on each supervisee's written supervision plan according to DHS Minnesota Statutes 9505.0371 Subpart 4 to:

1. Promote professional knowledge, skills, and values development.
2. Model ethical standards of practice

3. Promote cultural competency by developing the supervisee's knowledge of cultural norms of behavior for individual clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability. In addition, to address how the Supervisor's and supervisee's own cultures and privileges affect service delivery. The Clinical Supervisor needs to help develop the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed. This need to assess cultural competence is an ongoing process.
4. Recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment it planned and implemented.
5. Monitor, evaluate and document the supervisee's performance of assessment, treatment planning, and service delivery."

Clinical supervision needs to be conducted by a qualified Supervisor using individual or group supervision as defined by Minnesota Statutes 9505.0371 subpart 4. "Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes a minimum audio and video equipment for two-way, real-time, interactive communication between the Supervisor and the supervisee and meet the equipment standards of part 9505.0370 Subpart 19. Individual supervision means one or more designated Clinical Supervisors with one supervisee and group supervision is defined as one Clinical Supervisor with two to six supervisees in face-to-face supervision."

The supervision plan must be developed by the Supervisor and the supervisee according to Minnesota Statutes 9505.0371. The supervision plan must be:

1. "Reviewed and updated at least annually
2. For new staff the supervision plan must be completed and implemented in 30 days of employment
3. The supervision plan must also include the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised. The name and qualifications of the Supervisor. The number of hours of individual and group supervision to be completed by the supervisee and the method of supervision. The policy and method that the supervisee must use to contact the Clinical Supervisor during service provision. Procedures that the supervisee must respond to in case of a client emergency. And the authorized scope of practice including the description of the supervisee's service responsibilities, description of the client population, and treatment methods and modalities."

The clinical supervision must be recorded in the supervisee's supervision record according to Minnesota statutes 9505.0371 and include:

1. Date and duration of supervision
2. Identification of supervision type as either individual or group
3. Name of the Clinical Supervisor
4. Subsequent actions that the supervisee must take
5. Date and signature of the Clinical Supervisor

Qualified Clinical Trainee supervision requirements
A qualified clinical trainee who provides psychotherapy must receive clinical supervision. Individuals pursuing clinical licensure must be supervised by a licensed clinician for a minimum of one hour per week, and this supervision is documented and maintained on site.

Qualified clinical trainees with graduate degrees are required to follow all supervision requirements detailed in the following sources:

- Requirements specified in Minnesota Statutes 9505.0371 .
- Requirements published in the MHCP Handbook under the benefit for which they are providing services.
- All applicable MHCP provider regulations.

GETTING HELP

Support for supervision can be obtained by contacting you Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	CLINICAL COLLABORATION
Procedure Number:	305
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Consultation sign in sheet, meeting minutes

STATEMENT OF PURPOSE

The purpose of clinical supervision, consultation and clinical collaboration is to support staff and to monitor the quality of services we provide. Clinical supervision, consultation and clinical collaboration is conducted in a manner that satisfies the requirements of the State, the Council on Accreditation (COA), and other professional organizations with which the agency is affiliated. Additionally, Minnesota Statute 9505.0371, all licensed and non-licensed clinical staff who provide outpatient mental health services, will participate in clinical collaboration/supervision for at least one hour per week.

AREAS OF RESPONSIBILITY

Providers will attend weekly peer collaboration meetings, those that are unable to meet weekly will meet individually with another peer to collaborate.

Clinical Supervisor will take meeting notes and file afterwards.

PROCEDURE

The Minnesota clinical team meets weekly to review cases, assessments, treatment plans, and to provide another resource to staff for input on case decisions. This meeting time is documented and maintained via staff meeting notes and if needed in the client file. Those that are unable to meet weekly will meet individually with another peer to consult.

Clinical supervision and clinical consultation records shall be dated and documented with the signature of the person providing these functions in a supervision record. If clinical supervision or consultation results in a recommendation for a change to a client's treatment plan, the recommendation shall be documented in the client file.

Providers shall receive clinical supervision by a licensed treatment professional when clinically indicated or when critical incidents arise involving the client. Consultation regarding critical incidents shall also include the completion of the special incident report, and shall be documented in the client's file.

Critical incidents include:

- Major medical problems that either complicate the process of treatment, or serve as a barrier to successful treatment outcomes
- Continual "at-risk" behavior despite ongoing treatment
- Impairment of functioning that requires hospitalization
- Emergency detention
- Change in client functioning requiring a higher level of care
- Lack of progress toward treatment goals and objectives
- Co-occurring disorders
- Crises of self-harm or harm to others
- Complications resulting from significant and/or chronic substance use
- Aggressive acts within the clinic setting

GETTING HELP

Support for clinical case staffing can be obtained by contacting your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	CLINICAL CASE REVIEW
Procedure Number:	306
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Annual Program Viability Rating Procedure

STATEMENT OF PURPOSE

FCC monitors progress toward the overall quality of programs and functions through a cyclical Performance Quality Improvement (PQI) process to determine the status and achievement of consumer outcomes, and to identify any necessary corrective actions.

AREAS OF RESPONSIBILITY

Administrative Assistants and providers will conduct file reviews of current and discharged clients for all providers.

The coordinator will review results and address areas of concerns with providers.

The clinical Supervisor will provide clinical oversight of this process.

PROCEDURE

Administrative Assistants and providers will conduct file reviews quarterly for all providers. The Coordinator will review results and address any areas needing corrective action. Quarterly results and reports will be shared with providers at the clinical team meeting.

Providers shall receive clinical supervision by a licensed treatment professional when clinically indicated or when critical incidents arise involving the client. Consultation regarding critical incidents shall also include the completion of the behavioral incident report, and shall be documented in the client's file.

For more detail on the PQI Cycle, see the agency PQI Procedure 602.

GETTING HELP

Support for clinical case review can be obtained by contacting your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	TREATMENT PLANNING
Procedure Number	307
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	F244-1200 Outpatient MN Treatment Plan

STATEMENT OF PURPOSE

Individual treatment plans guide therapy and support clients' participation in their treatment as well as their understanding of the services being provided. Individual treatment plans also monitor the effectiveness of the ongoing treatment process

AREAS OF RESPONSIBILITY

Providers are directly responsible for creating and reviewing treatment plans (F244-1200 Outpatient MN - Treatment Plan) with clients and documenting necessary signatures. The Treatment Plan needs to address unmet service and support needs, taking the client's family relationship into consideration and the need of support from the client's informal support network. Providers will collaborate to provide clinical advice and review each other's treatment plans.

PROCEDURE

According to Minnesota Statute 9505.0371 Subpart 7 an Individual Treatment Plan (ITP) must follow these guidelines:

1. The client must be involved in the development, review, and revision of the ITP. During the development of the ITP the client is made aware of the available options for service, how the agency can help the client achieve desired outcomes and any benefits alternatives or risks to the planned services.

2. The ITP needs to be signed by the client before treatment begins. The provider will request that the client or other person authorized by statute to consent to mental health services for the client to sign the ITP or a revision of the ITP. For a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child will be asked to sign the child's ITP and revisions of the ITP. If client refuses to sign, the provider will document the reason for the refusal.

3. The ITP needs to be based on the current diagnostic assessment.

4. The ITP needs to be developed by identifying the client's service needs and considering cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives and timeframes for the client. The client will also participate in crisis and safety planning if it is appropriate to the individual's needs.

5. The ITP will be reviewed at least once every 90 days and revised as necessary. Revisions to an ITP do not require a new diagnostic assessment unless the client's mental health status has changed markedly. Families and significant others, as appropriate, of client are advised of ongoing progress with the consent of the service recipient.

GETTING HELP

Support for treatment planning can be obtained by contacting your Clinical or Administrative Supervisor.

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Procedure Name:	PROGRESS NOTES
Procedure Number	308
Domain:	Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	F244-1300 Outpatient MN Progress Note

STATEMENT OF PURPOSE

Progress notes are relative to the treatment plan and track progress over sessions. Progress notes assist in keeping the provider and client focused on the initial or subsequent goals.

AREAS OF RESPONSIBILITY

Providers are directly responsible for maintaining progress notes (F244-1300 Outpatient MN Progress Note).

PROCEDURE

Progress notes must be written after each therapy session, except in the case a Diagnostic Assessment is completed during the session. Progress notes shall contain problem and short-term objective information about the client that relates to the treatment plan/goals. Elements that are included in a progress note are the client's presentation, provider's interventions, the description of the session and the assignment/plan.

Progress notes are to be completed, signed, and dated by the provider performing the therapy session.

GETTING HELP

Support for progress notes can be obtained by contacting your Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	TIME ADD
Procedure Number:	309
Domain:	Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Alicia Skiles, MS, NCC
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

The time add procedure sends the details of client contact to the FCC Revenue Cycle department for billing and insurance purposes.

AREAS OF RESPONSIBILITY

Initiating time add as well as ensuring it accurately reflects client contact is the responsibility of the provider. Reviewing the time add information and billing insurance providers is the responsibility of the revenue cycle specialists.

PROCEDURE

To create a time add

1. Sign in to Procentive
2. Click on the “time” tab (column to the very left of the page).
3. Click on the “add” button at the very top of the page near the right.
4. A box should appear on your screen.
5. Fill in the appropriate information for Location, Staff, Client, program, CPT code, Diagnosis, Date, Start Time, End Time, Units, and Place.
6. Note that actual time spent with client, Start Time, End Time and Units should be in agreement.
7. If applicable, type in clinical supervisor’s name.
8. Click “save” at the bottom right hand corner.
9. The box should disappear as the time add is recorded.
10. Attaching a note
    a. *To write the note immediately:* A new box should appear; select program (drop down menu) and select the document form (progress note, diagnostic assessment) you wish to attach to the time add (note this should match the CPT code used in the time add). The note will appear and you can begin documenting.
    b. *To write the note at a later time,* delete the box that appears. Notice that your new time add line has been added to the list, also notice that a red colored page icon follows as part of the new line. When you wish to complete the note, come back to the “time” tab to pull up this page

and double click on this icon. A new box should appear; select program (drop down menu) and select the document form (progress note, diagnostic assessment) you wish to attach to the time add (note this should match the CPT code used in the time add). The note will appear and you can begin documenting.

To create a time add from a completed appointment

1. Sign into Procentive
2. Click on the "appointments" tab (column to the very left of the page).
3. Select the day of the appointment, you wish to create a time add for by clicking the arrows on the bar just above the schedule or by clicking the respective date on the calendar to the right of the page.
4. Highlight the appointment box by clicking on it once (should turn blue).
5. Notice that the column on the right hand side (under the calendar) changes to reflect that individual client's information.
6. Select "time add" that now appears in that column.
7. A box should appear on your screen with client information auto filled.
8. Review for accuracy Location, Staff, and Client.
9. Select appropriate program (drop down menu).
10. Type in appropriate CPT code.
11. Review for accuracy Diagnosis, Date, Start Time, End Time, Units, and Place.
12. Note that actual time spent with client, Start Time, End Time and Units should be in agreement.
13. If applicable, type in clinical supervisor's name.
14. Click "save" at the bottom right hand corner of the box.
15. A new box should appear, select program (drop down menu) and select the document form (progress note, diagnostic assessment) you wish to attach to the time add (note this should match the CPT code used in the time add). The note will appear and you can begin documenting.

Deleting a time add due to error

Contact the Revenue Cycle Department or the EHR Project Manager to delete a time add that was created in error.

GETTING HELP

Help for time add can be sought from your fellow providers, EHR Project Manager, Clinical Supervisor, Administrative Supervisor or the Revenue Cycle Specialist.

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Procedure Name:	REFERRALS/AFTERCARE
Procedure Number:	310
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	MN OP Procedure 303: Support Services www.greatriviers211.org MN OP 104: Emergency Services

STATEMENT OF PURPOSE

Clients who receive Outpatient Mental Health services that target goal-directed interventions for diagnosable conditions make gains in symptom reduction, improved self-management, and restored or enhanced daily functioning. At the time of discharge, it is necessary to set up supports and care for the client to continue receiving necessary services.

AREAS OF RESPONSIBILITY

Providers are directly responsible for providing the most current information available about a referral and assisting in the transition or attainment of referral services while still respecting the autonomy of the client. This referral process can take place during treatment and needs to be a part of the transition plan from treatment. This is done in a timely fashion so the client has the supports they need in place prior to discharge.

The Administrative Assistant will maintain the list of community referral sources that (or who) have completed business contracts with Family & Children's Center Outpatient Clinic.

PROCEDURE

Providers will refer clients to another provider for services that the clinic does not or is unable to provide to meet the client's needs as identified in the diagnostic assessment. Providers will also refer clients to other providers or resources to meet the needs of the client in preparation for discharge.

Providers will work with service recipients to identify and use natural resources and peer supports.

Clients in need of housing services, supported employment, medical care, substance use treatment, public benefits, educational services, respite care, family and parenting

support, financial assistance or other specialized services that would be best met by programs outside of FCC should be referred or linked with appropriate support services. Providers may or may not continue to work with clients after referrals. Providers will complete an **Authorization for Use & Disclosure of Health Information** prior to making a referral on behalf of the client. Providers will document any referrals made in the client file. Refer to MN OP Procedure 303: Support Services for a list of community resources.

Providers will offer families or significant others services including the following with individual's consent: family psychoeducation, emotional or family support and therapy, crisis intervention, self-help referrals, linkage to community and support services to meet basic needs, information, clinical guidance, support or care coordination as needed. Refer to MN OP 303: Support Service Procedure for a list of community resources.

Providers may assist clients with children to coordinate with childcare providers, child welfare system, courts and the school system as needed with appropriate authorizations. Please refer to MN OP 303: Support Services Procedure.

For the most current referral options, providers can also refer to the master list of referral sources and contact Great Rivers 211 for further options. Dial 211 or 1-800-362-8255. www.greatriviers211.org.

If a provider at the Family & Children's Center believes a client to be in danger of injuring themselves or others, the provider will follow MN OP 104: Emergency Services Procedure.

GETTING HELP

Support for referrals can be obtained by contacting you Clinical or Administrative Supervisor.

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Family & Children's Center

Procedure Name:	DISCHARGE PROCEDURES
Procedure Number:	311
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Services
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Services
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	F244-1400 Outpatient MN Discharge Summary, Discharge Letter, Follow up Survey

STATEMENT OF PURPOSE

Termination of services and after care planning represent important steps in client care. The following procedure details what is needed for client discharge.

AREAS OF RESPONSIBILITY

Providers are responsible for determining with clients when termination (or discontinuation of services) is needed.
Administrative Assistants will mail a discharge letter and follow-up survey

PROCEDURE

Mental Health Services:

The provider and client and/or family members and/or legal guardian jointly plan for voluntary termination of services when mutually agreed upon goals and objectives that were established at intake have been achieved as much as possible. The discharge summary (F244-1400 Outpatient MN- Discharge Summary) must be written within 30 days of the last session and must include the presenting problem, treatment given, progress, reason for discharge and after care/follow-up plan. The provider must also contact any collaborating community service providers.

Treatment terminated before its completion is also documented in a discharge summary. Treatment termination may occur if the client requests in writing that treatment be terminated or if the program terminates treatment upon determining and documenting that the client cannot be located, refuses further services, or is deceased.

The discharge summary includes all of the following:

- A description of the reasons for discharge
- A summary of the services provided, including any medications
- A final evaluation of the client's progress toward the goals set forth in the treatment plan

- Any remaining client needs at the time of discharge and the recommendations for meeting those needs, which may include contact information for any facilities, persons or programs to which the client was referred for additional services following discharge
- The signatures of the client and the mental health professional.

The client is informed of the circumstances under which return to treatment services may be needed.

Treatment terminated before its completion is also documented in a discharge summary. Treatment termination may occur if the client requests in writing that treatment be terminated or if the program terminates treatment upon determining and documenting that the client cannot be located, refuses further services, or is deceased.

Involuntary Discharge:

A client may be involuntarily discharged from treatment because of the client's inability to pay for services, canceling or "no showing" to three appointments or for behavior that is reasonably a result of mental health symptoms. In such cases, FCC must notify the client in writing of the reasons for discharge, the effective date of the discharge, sources for further treatment, and the client's right to have the discharge reviewed, prior to the effective date of the discharge. In the event that a client's third-party payer or benefits end, the provider must determine on a case-by-case basis their responsibility to continue providing services in critical situations.

Transfer of Cases:

When a provider transfers a client to another provider or if a change is made in the client's level of care, the provider will document the transfer or change in level of care in the client's case record. The documentation includes the date the transfer is recommended and initiated, the level of care from which the client is being transferred, and the criteria that are being used to make the determination for the appropriate level of care. The provider also sends a copy of the transfer documentation to the new provider, within a week after the transfer date.

Discharge Letter and Follow up Survey

After a discharge is complete, the Administrative Assistant will mail a follow-up survey, and track outcomes for PQI.

GETTING HELP

Support for discharge procedures can be obtained by contacting your Clinical or Administrative Supervisor. Back to Table of Contents

Procedure Name:	OUTPATIENT CLIENT SATISFACTION SURVEY
Procedure Number:	312
Domain:	Outpatient Minnesota
Approved By:	Vanessa Southworth, Director of Minnesota Programs
Created/Written By:	Vanessa Southworth, Director of Minnesota Programs
Effective Date:	8/1/19
Date(s) of Revision:	
References:	Client Satisfaction Survey

STATEMENT OF PURPOSE

In order to provide the best services possible, it is necessary to evaluate client perspectives of care. This survey will help give staff insight into client's thoughts regarding care. It will assist the organization in making necessary improvements to the outpatient therapy process.

AREAS OF RESPONSIBILITY

Providers are responsible for informing clients about the survey. Administrative Assistant will collect surveys on the way out at the front desk. The Director will be responsible for analyzing surveys and reporting on them quarterly.

PROCEDURE

The Administrative Assistant will ensure each Provider has printed copies of the Client Satisfaction Survey available. The Provider will ask clients, 14 and older, at the end of their session if they would mind taking two minutes to answer the seven question, likert scale, survey. If the client is under 14, the Provider can ask the parent to fill out the survey. The Provider will inform clients that their answers are anonymous and that they can drop the survey off in a box located at the front desk. The survey will be presented to clients once a month or every 4th session. The survey can be given verbally or translated, if the client requests assistance.

The Administrative Assistant will interoffice mail the surveys at the end of every month to the Director. The Director will make a copy and send to the Quality Improvement and Training Specialist. The Director will keep the original copy in a PQI file in their locked office.

GETTING HELP

Contact the Director for assistance with this procedure.

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Family & Children's Center

Procedure Name:	WINONA COMMUNITY HUB REFERRALS
Procedure Number:	313
Domain:	Minnesota Programs
Approved By:	Tita Yutuc, President/ CEO
Created/Written By:	Vanessa Southworth, Director of Minnesota Programs
Effective Date:	2/17/2020
Date(s) of Revision:	
References:	Memorandum of Understanding (MOU); Referral Criteria for Winona Community HUB; Children's Watch, Hunger Vital Sign; How To Make a Referral to Winona Community HUB

STATEMENT OF PURPOSE

This procedure outlines the process for collaboration and referrals to Winona Community HUB.

AREAS OF RESPONSIBILITY

The Director of Minnesota Programs is responsible for ensuring all program staff are familiar with the Winona Community HUB and how to make referrals. Coordinators and Supervisors are responsible for reinforcing collaboration with Winona Community HUB by reminding their staff of the referral process. Individual direct service staff are responsible for screening clients for food insecurity by using the Hunger Vital Sign and making referrals directly to the Winona Community HUB as appropriate.

PROCEDURE

The Winona Wellbeing Collaborative (WWC) is a collective of multiple service and non-service providing agencies that have assembled to address social determinants of health impacting residents of Winona. The WWC also serves as governance body for the Winona Community HUB, which resides under Live Well Winona, a department of Winona Health.

The Winona Community HUB aims to coordinate care for high-risk residents of Winona across agencies. The Winona Community HUB will receive referrals of high-risk families that meet defined criteria, then assign these families to a Community Health Worker that supports the family in addressing their risk factors. The Winona Community HUB will use a platform called Care Coordination Systems (CCS) to receive referrals and document case progress.

Winona Health, on behalf of Live Well Winona, agrees to receive, assess eligibility and assign clients to a Community Health Worker (CHW) (if eligible) in a timely manner (2 business days). Live Well Winona will monitor and support the progress of the CHW in

closing risk-factor "pathways" in a timely manner (9 months to all pathway closure or if client is pregnant, 18 months). Live Well Winona agrees to communicate updates and final outcomes of the referred client back to the referring agency as permitted under the client's Release of Information

Family & Children's Center (FCC) agrees to engage in an agency determined screening process to confirm adherence to HUB referral criteria. FCC agrees to use the CCS tool for referral, and will not incur any additional cost other than in-kind time to use this system. FCC acknowledges that not all referred clients may be ultimately deemed eligible for HUB services. Additionally, if a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), FCC must abide by HIPAA privacy rules.

Attached is the WWC Hub Referral Policy and instructions for the use through CCS.

Winona FCC User name is: FCHILDRENSCENTER

The password is: FCCWNhub1

Your security answer is: main (you lived on Main Street in the 3rd grade)

Review the documents in the References section above for more details about FCC's collaboration with Winona Community HUB and how to make a referral.

Staff responsible for enrolling clients in programs will screen new referrals for food insecurity by using the Hunger Vital Sign (Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.).

The Hunger Vital Sign™ identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):

"Within the past 12 months we worried whether our food would run out before we got money to buy more."
"Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

GETTING HELP

For questions about the Winona Community HUB and the related referral process, please

contact the Director of Minnesota Programs, your Coordinator or your Supervisor.

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Procedure Name:	TELEHEALTH SERVICES
Procedure Number:	103
Domain:	Client Rights All FCC Programs
Approved By:	Leah Morken, Clinical Director
Created/Written By:	Mary Jacobson, Director of Programs Vanessa Southworth, Director of Programs
Effective Date:	6/15/2020
Date(s) of Revision:	
References:	APA Telehealth Training Informed Consent for Telehealth Services form Procedure 407: Case Record Overview Revenue Cycle Homepage Provider Assurance Statement for Telemedicine Telephonic Telemedicine Provider Assurance Statement

STATEMENT OF PURPOSE

Telehealth services have been approved through the end of the State of Emergency related to COVID-19. The agency anticipates that telehealth will remain an important method of service delivery throughout the COVID-19 pandemic and beyond. As such, we will stay abreast of rules and regulations regarding telehealth and update this procedure accordingly. This procedure outlines the roles, responsibilities and processes related to providing telehealth services.

AREAS OF RESPONSIBILITY

All staff proving telehealth services are responsible for knowing and understanding the information in this procedure. All staff providing telehealth services must participate in the online APA telehealth training or other telehealth training approved by the Clinical Director.

PROCEDURE

Telehealth is the practice of health care delivery of services, diagnosis, consultation, or treatment of medical data by means of audio, visual, or data communication. Telehealth services must be provided through a 2-way, real-time, interactive method of communication. This excludes voicemails, texting, emailing, faxing, and chat rooms.

Telehealth is not a “check-in”. It is a purposeful and intentional service that is medically needed as determined by a licensed medical professional or mental health professional. Services must be clinically appropriate for the consumer’s needs.

Methods of Telehealth:

Providers are expected to use HIPAA compatible modalities to protect consumer rights. Family & Children's Center complies with established state and federal regulations for telehealth.

Family & Children's Center prefers the use of doxy.me for secure telehealth services and has provided a select number of accounts for providers in need of a secure platform that allows for screen sharing capabilities. Providers are responsible for ensuring the platform they are using is an approved platform by confirming with the Clinical Director. Approved platforms may vary with time based on regulations.

FCC expects all providers to adhere to the requirements of Health Insurance Portability and Accountability Act (HIPAA). This requires taking necessary steps to protect the privacy of clients and the confidentiality of information related to providing services via telehealth. Providers should refer to agency procedures related to HIPAA as well as the APA telehealth training or other approved training if they have questions. For additional help, they should contact the Clinical Director.

Telehealth Process:

Prior to providing any telehealth services, providers must obtain consent from clients via the Informed Consent for Telehealth Services form. Signed and written consumer consent is preferred; however, if written consent is unable to be obtained, then verbal consent is allowable while documenting the efforts to obtain written consent. This can be done via email or regular mail. If verbal consent is utilized, it must be obtained at the start of every session after the risks of telehealth to privacy are discussed.

Providers must adequately address client safety before, during, and after the telehealth service is rendered. This may include but is not limited to a review of client records to identify history of safety risks, creation of a safety plan and protocol for staff members, on-going assessment of client's symptoms and potential safety risks via question and aftercare referral and submission of the created safety plan to the next provider.
The following information must be communicated and discussed with the client at the start of every session:

- An understanding that others may hear the conversation in the background
- Staff's location and environment (ex: working from home with dogs that may bark in the

  background)
- An understanding that the platform used may not be confidential (e.g., if the

platform is not HIPAA compatible, such as Skype, data storage, 3rd party recordings, internet security breaches, etc.)

- An understanding that the consumer has the right to refuse or stop the session at any time
- An understanding that the provider may end the session if the connection is poor or for other reasons that should be explained to the client

Requirements for Documentation:
Staff documentation expectations remain in effect, including the use of the SIRP method of documentation. However, additional requirements must be clearly documented in every case note. This information includes:

- Method/mode of transmission used for session (e.g., Skype, telephone call, etc.)
- A description of the provider's basis for determining that telehealth is an appropriate and effective means for delivering service to the client (e.g., due to COVID-19, due to Safe at Home Order, due to client being unable to come into the office, due to client not having internet connection—in the case of a telephone session, etc.)
- Type of service provided (e.g., outpatient counseling session, supervised visit, etc.)
- Location of consumer (as confirmed by provider) and location of provider (e.g., "Due to consumer self-quarantine, writer called from office to consumer in their home", etc.). This is also known as the location of the originating and the distant site.
- That risks were reviewed and provider received consent for telehealth (Ex: "Current signed consent for telehealth", "Verbally reviewed risks and received verbal consent to conduct session via telehealth", etc.)
    - Ask and document assurance that the client is in a place with privacy, and if they are not, who else is present?
    - Ask and document that the client moved their camera around so you can see the physical setting of the room they are in.
    - Review and document the procedures for disconnection (sign back into the telehealth platform, and if that does not work what number to call by

telephone to reconnect with the client) and your safety plan for emergency contact if needed.

- Time the service began and ended, with a.m. and p.m. designations

Addressing How and When to Discontinue Telehealth Services:
The following criteria should be utilized to address how and when telehealth services should end:

- Evaluation of service (intervention used and client's response): Daily review of progress notes
- Evaluation of on-going needs of the client: Clinical consultation of client cases either weekly, monthly, or as needed depending on circumstances
- Evaluation of scope of practice and client's needs: Clinical consultation of client cases either weekly, monthly, or as needed depending on circumstances
- If it is determined a client is not a fit for telehealth services, then an option may be to initiate in person services.

Process for discontinuation:
Context

- Client demonstrates deterioration or a need for higher level of care
- Client has on-going missed appointments or cancellations over a 3-week period
- Client decides to discontinue services
- Client's additional community providers report concern due to client's deterioration in functioning

Protocol

- Staff will consult with Clinical Supervisor
- Staff will consult with outside providers (e.g., County Case Manager)
- Staff will make 3 attempts to discuss potential discharge with client
- Staff will complete a discharge summary
- Staff will provide a referral for aftercare and follow-up

Billing Requirements:
There are no changes to service note billing requirements. However, invoices must add an indicator for telehealth services. For information on how to bill for telehealth services by payer, please go to the Revenue Cycle Homepage on the Depot. This can be accessed by going to Directory > By Department > Revenue Cycle Management > Click here to visit the Revenue Cycle Homepage!

In Minnesota, billable provides must complete the Provider Assurance Statement for Telemedicine, which is submitted to Medicaid and other payers as required, by the

Revenue Cycle Department. Also, in Minnesota if any provider offers telephonic services, they must complete the Telephonic Telemedicine Provider Assurance Statement.

GETTING HELP

If you have questions regarding this procedure, please contact your Program Supervisor, Coordinator, Director or Clinical Director.

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Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

One of FCC's values is excellence, a commitment to providing the highest quality services to our consumers, employees and community. Our personnel policies embody this value by setting high standards for qualifications, training and conduct.

AREAS OF RESPONSIBILITY

Administration, provider and staff work together to ensure personnel requirements are met and quality standards are maintained.

PROCEDURE

Qualifications:

The outpatient clinic must have a state certified Clinic Supervisor who is responsible for clinic operations, including ensuring that the clinic is in compliance with applicable state and federal laws. The Clinical Supervisor must demonstrate the ability to provide structure and support to staff in order to reduce stress, anxiety, secondary traumatic stress and vicarious trauma. They also need to process and debrief with staff following a crisis or traumatic event, create an atmosphere of problem solving and learning, and build and maintain morale. They will work with the outpatient team to provide a variety of constructive ways to approach difficult situations with clients and give regular feedback, offer growth opportunities and structure to maintain ongoing communication and feedback.

The Qualifications of the Clinical Supervisor according to MN DHS statute 9505.0370 are:

- A licensed mental health professional
- Hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice
- Be approved, certified or in some other manner recognized as a qualified clinical Supervisor by the person's professional licensing board, when this is a board requirement
- Be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised

- Not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years
- Have experience and skills that are informed by advanced training, years of experience and mastery of a range of competencies that demonstrate the following:
- Capacity to provide services that incorporate best practice
- Ability to recognize and evaluate competencies in supervisees
- Ability to review assessments and treatment plans for accuracy and appropriateness
- Ability to give clear direction to mental health staff related to alternative strategies when a recipient is struggling with moving towards recovery
- Ability to coach, teach and practice skills with supervisees
- Accept full professional liability for a supervisee's direction of a recipient's mental health services
- Instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with recipients
- Review, approve and sign the diagnostic assessment, individual treatment plans and treatment plan reviews of recipients treated by a supervisee
- Review and approve the progress notes of recipients treated by the supervisee according to the supervisee's supervision plan
- Apply evidence-based practices and research-informed models to treat recipients
- Be employed by or under contract with the same agency as the supervisee
- Develop a clinical supervision plan for each supervisee
- Ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices
- Establish an evaluation process that identifies the performance and competence of each supervisee and document clinical supervision of each supervisee and securely maintain the documentation record

Clinical Supervisors who supervise clinical trainees must complete the Qualified Mental Health Professional Clinical Supervision Assurance Statement form (DHS-6330) in order for clinical trainee’s time spent conducting diagnostic assessments, psychotherapy or explanation of findings to be billed.

The clinic shall have a sufficient number of qualified staff members available to provide outpatient mental health services to clients admitted to care. The clinic will provide

services to individuals age 13 and younger and must have personnel qualified by training and experience to work with children and adolescents.

An individual whose professional license is revoked, suspended, or voluntarily surrendered may not be employed or contracted with as a mental health or treatment professional or prescriber. An individual whose license is limited or restricted will not be allowed to practice in areas prohibited by the limitation or restriction.

When hiring, consideration is given to each applicant's competence, responsiveness, and sensitivity toward and training in serving the characteristics of the service's patient population, including gender, age, cultural background, sexual orientation, developmental, cognitive or communication barriers and physical or sensory disabilities. Each staff member is required to adhere to all laws and regulations governing the care and treatment of clients and the standard practice for their individual profession, including guidelines for licensure.

Providers may also maintain certain certifications from state or national credentialing organizations. If such certifications are required by the agency, then the agency will pay for the cost. The cost of other certifications not required by the agency may be the responsibility of the Provider. The Director will decide whether the cost will be partially or fully be covered by the agency on a case-by-case basis.

The following persons may provide psychotherapy services through an outpatient clinic:

1. A qualified clinical trainee. Qualifications include:
    - A mental health practitioner who is complying with requirements for licensure or board certification as a mental health professional, including supervised practice in the delivery of mental health services for the treatment of mental illness
    - A student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional
    - The mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently and includes the supervision of: direct practice, treatment team collaboration, continued professional learning, and job management.
2. Any of the following licensed mental health professionals:
    - Independent Clinical Social Worker, Professional Counselor, or Marriage and Family Therapist.

Clinical Competency

All clinical personnel are required to show competency in the following areas;

- Crisis prevention and intervention
- Identifying needs of exploited, abused, and neglected children and adults and reporting to proper authorities
- Understanding child development and individual and family functioning
- Working with difficult to reach and disengaged families and individuals
- Determining if a higher level of service is needed
- Recognizing and working with individuals with co-occurring conditions
- Collaboration with other disciplines and services

GETTING HELP

Support for Personnel can be obtained by connecting with your Clinical or Administrative Supervisor or FCC HR Department.

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Procedure Name:	MN OP BACKGROUND CHECK PROCESS
Procedure Number:	402
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Services
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Background Check Policy/ Procedure

STATEMENT OF PURPOSE

One of FCC's values is excellence, a commitment to providing the highest quality services to our consumers, employees and community. Our personnel policies embody this value by setting high standards for qualifications, training and conduct.

AREAS OF RESPONSIBILITY

Supervisors follow hiring policies to complete required paperwork for a potential employee prior to offer.

Administrative Assistant will complete initial background checks and at least every four years.

Employees are responsible for notifying the agency *immediately* of any background changes including being convicted of a crime, being investigated by any governmental agency for any other act, offense, or omission, including an investigation related to the abuse or neglect, or threat of abuse or neglect, to a child or other client, or an investigation related to misappropriation of a client's property, having such a finding substantiated by a governmental agency, or being denied a professional license or having the license restricted or limited;

Credential holders must report any convictions to the Department of Regulations and Licensing within 48 hours.

PROCEDURE

Family & Children's Center has implemented policies to protect our clients from potential abuse by our own employees. The agency has a zero tolerance policy in regards to substantiated cases of abuse by an employee. Any employee found to have abused a client will be terminated immediately and the incident will be reported to the appropriate authorities.

Family & Children's Center conducts extensive background checks on all potential and/or new employees. These checks are conducted in every state in which the employee has lived for the past three years. Any applicant found to have a record of abuse, drug involvement, or any other crime involving children or vulnerable adults will not be considered for employment. The agency conducts background checks at least every four years after hire and/or if a supervisor requests an additional check on a specific employee.

GETTING HELP

Support for Personnel can be obtained by connecting with your Clinical or Administrative Supervisor or FCC HR department.

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Procedure Name:	TRAINING
Procedure Number:	403
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Services
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Services
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	Staff Training & Development Procedure

STATEMENT OF PURPOSE

One of FCC's values is excellence, a commitment to providing the highest quality services to our consumers, employees and community. Our personnel policies and procedures embody this value by setting high standards for qualifications, training and conduct.

AREAS OF RESPONSIBILITY

Staff are required to complete initial and annual training requirements and provide documentation of trainings completed for their employee file.

PROCEDURE

Staff members shall receive initial and continuing training that enables the staff member to perform their duties effectively, efficiently, and competently. They need to continue their education and training in order to deliver culturally and linguistically responsive care, and stay up to date on evidence-based practices and bodies of knowledge. Ongoing training in the areas of social, economic and environmental factors that may affect clients is also required including any electronic interventions. Staff members must obtain the training required for the maintenance of their professional license, in addition to completing agency training requirements. Family & Children's Center maintains current training records for staff members.

Upon hire, all employees are required to attend Employee Orientation. Employees are required to obtain continuing education hours per year. See Training Procedure.

In addition, staff must obtain any training required to maintain their certification/licensure (i.e. Ethics and Boundaries, Trauma-Informed care practices, suicide risk). Each employee is responsible for obtaining and documenting their own staff development time by signing the attendance sheet for in-house workshops or by filling out the bottom portion of their timesheet for other workshops or training. Information regarding seminars and workshops will be noted on the depot. Attendance at any out-of-

agency workshops or seminars must be pre-approved by the Program Director and should be related to their scope of practice.

Orientation training requirements are reviewed upon being hired and annually:

1. A review of applicable Minnesota statutes and regulations
2. A review of the clinic's policies and procedures
3. Cultural factors that need to be taken into consideration in providing outpatient mental health services for the clinic's clients
4. The signs and symptoms of substance use disorders and reactions to psychotropic drugs most relevant to the treatment of mental illness and mental disorders served by the clinic
5. Techniques for assessing and responding to the needs of clients who appear to have problems related to trauma; abuse of alcohol, drug abuse or addiction; and other co-occurring illnesses and disabilities
6. How to assess a client to detect suicidal tendencies and to manage persons at risk of attempting suicide or causing harm to self or others
7. Recovery concepts and principles that ensure services, and supports connection to others and to the community
8. Any other subject that the clinic determines is necessary to enable the staff member to perform the staff member's duties effectively, efficiently, and competently

GETTING HELP

Support for Personnel can be obtained by connecting with your Clinical or Administrative Supervisor and/or FCC HR Department.

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Family & Children's Center

Procedure Name:	DIRECT CONTACT
Procedure Number	404
Domain:	Outpatient
Approved By:	Tita Yutuc, LCSW, President/ CEO
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs Revised by: Karen Wrolson, Director of Minnesota Programs Revised by: Vanessa Southworth, Director of Minnesota Programs
Effective Date:	1/13/2017
Date(s) of Revision:	3/15/2018, 6/3/2019
References:	

STATEMENT OF PURPOSE

One of FCC's values is excellence, a commitment to providing the highest quality services to our consumers, employees and community. Our personnel policies embody this value by setting high standards for qualifications, training and conduct.

AREAS OF RESPONSIBILITY

Administration, provider and staff work together to ensure personnel requirements are met and quality standards are maintained.

PROCEDURE

Therapists are expected to maintain 70% direct contact time. Therefore, providers who have a full-time position of 40 hours per week are required to have 28 billable hours within each 40 hour pay period. Providers who are working in a half-time position of 20 hours per week should have 14 billable hours within each 20 hour pay period. In any other arrangement of hours per week, providers must maintain the 70% direct contact time.

The Accounting Specialist with input from the Revenue Cycle Supervisor prepares a direct contact report for each outpatient provider monthly based on:

- Hours worked in Outpatient as recorded on each provider's timesheet
- Number of billable appointments per Procentive report 8030 in comparison with
  the Appointment Summary report 6140

This report is shared with the Program Supervisor and Director, who ensure the information is shared with the providers.

New providers are allowed up to three months to achieve the 70% required direct contact time. Following that initial period, the Program Supervisor will meet with therapists who

have not met and/or who are not maintaining the 70% requirement. S/he will review the circumstances related to this issue including amount of referrals received. If there are no contributing factors creating the lower percentage, one or more of the following may occur:

- The Program Supervisor and the provider will create an action plan to resolve the concern within one month;
- The provider may be reduced to part-time status;
- The provider may be assigned hours in another program;
- Disciplinary action may be taken.

Should a provider's hours in Outpatient be reduced to less than full-time, s/he may be eligible to return to full-time after demonstrating the ability to maintain the required 70% direct contact time for a period of not less than three months. This decision will be at the discretion of the Program Supervisor who will take into account the provider's work record, program need, current referrals, as well as other related information.

GETTING HELP

Support for direct contact can be obtained by connecting with your Clinical or Administrative Supervisor or FCC HR department.

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Procedure Name:	SCHEDULING
Procedure Number:	405
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Cooridnator of Community Service Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

One of FCC's values is excellence, a commitment to providing the highest quality services to our consumers, employees and community. Our personnel policies embody this value by setting high standards for qualifications, training and conduct.

AREAS OF RESPONSIBILITY

Administrative Assistants manage provider schedules.
Providers will communicate schedule needs to the Administrative Assistant.

PROCEDURE

It is the provider's responsibility to inform the Administrative Assistant of their available hours to see clients as well as any schedule changes, time off, meetings and trainings.

Sessions must be held within the hours the clinic is scheduled to be open, unless approved by the supervisor. All sessions must be scheduled with the Administrative Assistant. Providers may not hold "unscheduled" or "off-the-books" sessions. Providers will get time off approved by their Supervisor then inform the Administrative Assistant.

GETTING HELP

Support for Personnel can be obtained by connecting with your Clinical or Administrative Supervisor or FCC HR department.

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Family & Children's Center

Procedure Name:	PRIVATE PRACTICE
Procedure Number	406
Domain:	MN Outpatient
Approved By:	Leah Morken, Director of Minnesota Programs
Created/Written By:	Amanda Jalensky, Coordinator of Community Services Leah Morken, Director of Minnesota Programs
Effective Date:	10/16/2017
Date(s) of Revision:	
References:	

STATEMENT OF PURPOSE

One of FCC's values is excellence, a commitment to providing the highest quality services to our consumers, employees and community. Our personnel policies embody this value by setting high standards for qualifications, training and conduct.

AREAS OF RESPONSIBILITY

Administration, provider and staff work together to ensure personnel requirements are met and quality standards are maintained.

PROCEDURE

It is imperative that professional practice outside of the Family & Children's Center must not conflict with the practice or operation of FCC.

The Employee Handbook states: "An employee will not be permitted to work for another employer who is in competition with FCC, solely determined by FCC. In addition, an employee will not be permitted to work for another employer while on a leave of absence or while absent for illness from FCC. Employees cannot request time off at FCC to work another job."

The Director must be informed of and approve of outside professional employment by the provider. A provider may not provide services for agency clients in a private practice setting or see non-FCC clients at Family & Children's Center. Therapists may not provide "pro bono" work or negotiate fees with clients.

GETTING HELP

Support for Personnel can be obtained by connecting with your Clinical or Administrative Supervisor o FCC HR department.

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Family & Children's Center

Procedure Name:	PQI
Procedure Number:	501
Domain:	Outpatient Minnesota
Approved By:	Vanessa Southworth, Director of Minnesota Programs
Created/Written By:	Vanessa Southworth, Director of Minnesota Programs
Effective Date:	8/1/2019
Date(s) of Revision:	
References:	604 Peer Record Review, 101 PQI Procedure, MN OP Peer Record Review Checklist, Outpatient Minnesota QSR, MN OP PQI Program Report

STATEMENT OF PURPOSE

FCC reinforces continuous improvement and the overall quality of programs and functions through a cyclical Performance and Quality Improvement (PQI) process. This procedure outlines the process for Outpatient Minnesota.

AREAS OF RESPONSIBILITY

All Outpatient Minnesota staff will be involved in the PQI cycle on different levels. The PQI cycle begins with the providers and Administrative Assistant. The next level involves the Program Director, who then report to the Senior Leadership Team quarterly on all their programs.

PROCEDURE

File Reviews:

Quality Improvement and Training Specialist will send out peer record review checklists and instructions to all program supervisors during the last month of the quarter.

Outpatient Minnesota reviews 10 open files and two closed files. Where possible, please select files that were not reviewed the previous quarter.

The Program Supervisor will assign files to program staff and provide a list of client numbers to each staff member in order to access the records via Procentive. Staff must have view access granted for the file review timeframe, and this can be granted by contacting the EHR Project Manager. Each program's peer record review checklist should correspond with the format of their files and specific program needs. For each section listed on the checklist, check if the form or information requested is in that section of the file.

- If the form listed is not present in the file or is missing any required information, simply check “NO” on the checklist and check the box “Requires Attention” and move on to the next item listed. You may also include additional comments on the checklist as needed.
- If the form is not present but also not required (i.e. a discharge summary is not required if a client is still active), check “N/A” on the checklist.
- If the form is present in the file and includes all required information, check “YES”.
- If the form is present, make sure the form includes any information listed that is required for that form (i.e. signatures, dated within a set period, etc.).

After all files have been reviewed by a staff member, the completed peer record review checklists will be sent to and reviewed by the Program Supervisor. If the file passes, you are good to go -- send Program Coordinator, Program Director, and QI Specialist the peer record review checklist, make sure the client’s file review section on Procentive is filled out, and you are all set.

If the file needs improvement, the checklist will be forwarded to the provider. The provider will carefully review the checklist for areas where the file requires attention, and address those areas as needed. Once all items have been addressed, check off the “Corrected” box on the checklist and state the resolution in the “Comments/ Resolution box”. If there is no resolution, write a comment explaining why and then send the improved checklists back to the Program Supervisor. The Program Supervisor will forward to the Program Coordinator, Program Director and QI Specialist the peer record review checklist and make sure the client’s file review section on Procentive is filled out. After all completed peer record review checklists have been turned in electronically, the Quality Improvement and Training Specialist will randomly select five “corrected” items to review. This process will assure the items are accurately corrected and the file is compliant. If the item is falsely corrected the Program Director will be notified to follow-up on this action.

Family & Children's Center

Quarterly Statistical Report (QSR):

Quarterly outcomes data is generated using reports available in Procentive whenever possible. When it is not possible to pull reports from Procentive, data will be calculated manually.

The outcomes and corresponding process for producing the outcomes data are as follows:

1. **Combined client no-show and cancelation rate will not exceed 35%.**

- Utilize Procentive Report #3410 Appointment Status Summary (NEW)
  - Put in date range for quarter (e.g., 4/1/19 to 6/30/10) or select quick range last quarter
  - Put in appointment location (Winona)
  - Put in client location (Winona)
  - Don't select default program, primary payer, or staff
  - Check box for group by option
  - Group by staff
  - Click display
- Add up the total client cancelled, late cancel and staff cancelled appointments. Take this total and divide it by the number of total appointments. Next, multiply this number by 100, and that equals the cancelation rate for that quarter. Example: 21 client cancelled + 10 late cancel = 31 / 216 total number of appointments = 0.1435185 X 100 = 14.35%

2. **Clients have met 66% of treatment goals at time of discharge.**

- There is not a Procentive report to pull this information at this time. The EHR Coordinator is working with Procentive to make this happen. Until then, here is how to access the necessary information:
- From Clinical/Charting tab in Procentive, conduct the following search:
  - At the bottom of screen, click Select All to clear out search fields
  - Select staff from the dropdown box
  - Select Program: Outpatient Services - Winona

- Select Quick Range: Last Quarter
- Click Search at bottom of the screen
- Go through the list and select each Outpatient MN – Discharge Summary by double clicking on it
- Note the goals completed for each client, keeping track of the number met compared to number of goals
- After doing this for every discharge summary, total the number of goals met
- Divide the number of goals met by the total number of goals and multiply this by 100 to get the percentage of goals met

Example: 13 goals met / 38 total goals = 0.34210526 X 100 = 34.21%

3. 10 new client intakes

- Utilize Procentive Report #3150 Intake Detail
  - Select Quick Range: Last Quarter
  - Select Program: Outpatient Services - Winona
  - Sort by: Staff
  - Client date: Date of intake
  - Click Display
  - Count the number of clients that had a First Service date, and this is the number of new client intakes for the quarter.

4. 75% of new appointments are available to be scheduled within 2 weeks of referral.

- Utilize Procentive Report #3150 Intake Detail
  - Select Quick Range: Last Quarter
  - Select Program: Outpatient Services - Winona
  - Sort by: Staff
  - Client date: Date of intake
  - Display Days b/t Intake and Illness: select No
  - Click Display

- Count how many times there were more than 14 days between the Intake Date and First Service. Take this number and divide it by the Total Count of intakes. Then multiply this number by 100 to get the percentage.

Example: There were two appointments that had First Service dates more than 14 days from the Intake Date, and there were 10 total intakes, so 2 / 10 = 0.2 X 100 = 20%

PQI Staff Meeting:

The Program Supervisor will schedule a staff meeting at the beginning of a new quarter to discuss and review file checklists and statistical quarterly reports from the previous quarter. The Program Supervisor will send out an email to all program staff, Program Director and QI and Training Coordinator notifying them of the time, date, and location of the PQI meeting.

Before the staff meeting takes place client files are to be reviewed and checklists are to be completed by assigned staff members. Please see the Peer Record Review Procedure in the References section of this document for further instructions on file reviews.

The Supervisor is responsible for completing quarterly statistical reports (QSR) before the PQI staff meeting, and completing the PQI Program Report at the staff meeting and sending it electronically to the Coordinator after the meeting is finished. See the Quarterly Statistical Report Form and the PQI Program Report Form in the References Section of this document for further instructions on how to complete this form.

PQI Program Report:

Open the PQI Program Report. Make sure the program name (Minnesota Outpatient) and reporting period are indicated.

1. **File Reviews:**
   - Date and Name of Program Supervisor - Fill in this area according to when Peer Record Review was completed and current supervisor names

- Area(s) Requiring Improvement – This is where the notes taken when reviewing the Peer Record Review Summaries will be entered. Bullet point the area(s) that needed attention.
- Action Steps – Include a summary of what was missing and trends that may have been attributed to why these areas needed attention. Include an action plan with who may be included in the action steps and what the action steps will be.
- Time Frame for Correction – Enter in the deadline for the Action Steps
- Responsible Persons – Enter in the specific names of the staff who will be executing the actions steps to make the corrections (typically will be the program case manager, therapist, coordinator and clinical supervisor).

2. Incident Reports

- Date and Name of Program Supervisor - Fill in this area
- Area(s) Requiring Improvement – Enter in the total number of incidents for the type of Incident Report (Injury, police contact, physical aggression, risk assessment, etc).
- Action Steps – Include a summary of what types of incident reports were higher that quarter. Include actions steps that will be included for helping staff respond and to try and help prevent further incidents from happening.
- Date of Deadline – Enter in the date deadline for the action steps.
- Responsible Persons – Enter who will be involved in the action steps. This may include program therapist, clinical supervisor, Director, etc.

3. External Audits

- Date and Name of Program Supervisor - Fill in this area according to when Peer Record Review was completed and current supervisor names.
- Area(s) Requiring Improvement – This area will only have results depending on if there was an external audit. Typically the external audits will be COA or the state for licensing/certification. If there was no audit simply enter "no audit."

- Action Steps – If there was an audit, give a summary of what was asked to be changed.
- Date of Deadline – Since these actions steps are usually gradual and take time, be specific in the "action steps" of how the programs will carry these steps out and when the changes will start.
- Responsible Persons – Enter who is involved in this process. This may include program therapist, clinical supervisor, Director, etc.

4. Client Satisfaction Surveys

- Date and Name of Program Supervisor - Fill in this area.
- Area(s) Requiring Improvement – enter the number of discharges for that quarter.
- Action Steps – In the action steps indicate whether or not client surveys were sent out for the discharges that occurred during that quarter. If any client surveys were received from previous quarters, enter the results in the "observations" portion of this section.
- Date of Deadline – Enter deadline for getting client surveys sent out that were not sent.
- Responsible Persons – Enter the names of who will be sending out the surveys. Typically this will be the Administrative Assistant.

5. Outcomes

- Date and Name of Program Supervisor - Fill in this area.
- Area(s) Requiring Improvement – Enter in "Goals Met" if the Goal Outcomes from the QSR report were met or "Goals Not Met" if the Goal Outcomes were not met. If one outcome is not met, still mark as "Goals Met" but list what section was not met.
- Action Steps – In this area enter in the goal(s) that were not met including the results compared to targets, to illustrate the difference. Include in the action steps what will be done to help meet the unmet goal(s) in the future quarter(s). May

include action steps that will be taken to make sure the goal areas that were met continue to stay met.

- Date of Deadline – Deadline for the action steps.
- Responsible Persons – Enter who is involved in this process. This may include program therapist, clinical supervisor, Director, etc.

6. Program Marketing Plan

- Indicate in the first box whether goals were "Met" or "Not Met."
- In the "Comments" box, summarize what was done during the reporting quarter and what plans may be for the next quarter as well as anything else of note.

Program Coordinators are responsible for sending PQI Program Reports to Quality Improvement and Training Specialist and Program Director after they have reviewed them. Once all PQI documents have been turned in, Program Directors will attend a Senior Leadership meeting and share their top five most important quarterly observations, which will vary from their programs' PQI elements. The Quality Improvement and Training Specialist will share apparent trends that may fluctuate from any collected PQI data across the agency.

GETTING HELP

If you are in need of any additional guidance or have questions regarding the PQI Procedure for Outpatient Minnesota, please do not hesitate to contact the Program Supervisor.

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