

RECORDS MANAGEMENT AND DOCUMENTATION MANUAL

For

Providers of Publicly-Funded Mental Health, Intellectual or
Developmental Disabilities, and Substance Use Services

and

Local Management Entities-Managed Care Organizations



North Carolina

Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

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APSM 45-2

Effective July 1, 2016



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APPENDIX A

STANDARDIZED FORMS

Certification of Need for Institutional Care for Individual Under Age 21
Child/Adolescent Discharge Plan
Person-Centered Plan template
Record Storage Log
Request for Disposal of Unscheduled Records

**DIVISION OF MEDICAL ASSISTANCE
CERTIFICATION OF NEED FOR INSTITUTIONAL CARE
FOR
INDIVIDUAL UNDER AGE 21**

The purpose of this form is to communicate between the county department of social services, attending physician, and Division of Medical Assistance (DMA) about the anticipated duration of treatment for an individual under age 21. The information is required for a determination of financial eligibility for Medicaid.

SECTION A: REQUEST TO PHYSICIAN (Completed by County DSS)

Name of Individual _____ Date of Birth _____

Medicaid coverage has been requested for medical care and treatment in an institutional setting for the above-named individual. The place and the expected duration of care and treatment are required in order to establish financial eligibility for Medicaid.

PHYSICIAN: Please complete SECTION B and also SECTION C, if appropriate, and ATTACH REQUESTED MEDICAL RECORDS AND DOCUMENTATION. **Return as soon as possible to:**

_____ County DSS

Attention: _____ (Caseworker)

Date of Request: _____

SECTION B: RECOMMENDED DURATION OF CARE AND TREATMENT

1. Based on primary diagnosis of _____

and secondary diagnosis of _____
continuous care and treatment are recommended as follows:

a) Medicaid Certified Facilities:

- (1) _____ months, acute care general or psychiatric hospital
- (2) _____ months, inpatient substance abuse hospital
- (3) _____ nursing facility (skilled or intermediate care)
- (4) _____ months, intermediate care/mentally retarded
- (5) _____ months, psychiatric residential treatment facility

b) Non-Medicaid Facilities (not covered by Medicaid):

- (1) _____ months, residential treatment
- (2) _____ months, therapeutic group home
- (3) _____ months, other (specify type): _____

2. Medical records/documentation are needed when continuous care and treatment in a Medicaid-certified medical institution are expected to exceed 12 months or more. The following records and/or documentation are enclosed:

- a) _____ For skilled or intermediate nursing care, FL-2 only
- b) _____ For intermediate care for the mentally retarded, MR-2 only

- c) _____ For acute inpatient care in a general hospital, psychiatric hospital, substance abuse hospital, or psychiatric residential treatment facility, (submit all available records)
- _____ History of current illness
 - _____ Official medical records for past 6 months
 - _____ Discharge summaries for all inpatient, residential, or group home placements for past 12 months or dates of same
 - _____ List of current medications
 - _____ Plan of care with goals and time frames

3. Care is to be provided at _____
 _____ (Name of institution or facility)
 beginning on (date) _____

4. I (will / will not) be treating this individual in this institution/facility.

SECTION C: PHYSICIAN CERTIFICATION (Completed by attending physician)

I understand this certification form is for the purpose of establishing financial eligibility for Medicaid and not for the purpose of determining medical necessity for the recommended care and treatment stated in SECTION B.

I certify that the recommended care and treatment and the expected duration of such care and treatment are based on my best judgment and evaluation of the individual's current medical condition and needs and that a false certification or misleading statement which results in Medicaid payments for which the individual would not otherwise have qualified may subject me to civil and criminal penalties.

Physician's Name: _____ Phone No. _____

Physician's Signature: _____ Date: _____

Address: _____

SECTION D: DMA APPROVAL FOR DETERMINATION OF FINANCIAL ELIGIBILITY (Completed by DMA)

This approval authorizes the county DSS to establish financial eligibility of the named individual without regard to the income and resources of the parents. Neither the county DSS nor DMA is making a determination that institutional services are medically necessary. DMA expressly reserves the right to review the medical necessity of institutional services reimbursed by the Medicaid program, to recover improper payments, and to prosecute any person suspected of knowingly and willfully making or causing to be made a false statement or representation of a material fact intended for use in determining entitlement to Medicaid coverage.

Name of authorized agent: _____

Title of authorized agent: _____

Signature of authorized agent: _____

Date: _____

Consumer Name _____ Service Record # _____

Date the Child and Family Team met to develop this discharge/transition plan: _____

Division of MH/DD/SAS
Division of Medical Assistance

Child/Adolescent Discharge/Transition Plan

This document must be submitted with the completed ITR, the required PCP (i.e. introductory, complete or update) and any other supporting documentation justifying the request for authorization and reauthorization of Residential Levels III and IV. In addition, for reauthorization of Residential Level III and IV, a new comprehensive clinical assessment by a psychiatrist (independent of the residential provider and its provider organization) that includes clinical justification for continued stay at that level of care is required to be submitted. An incomplete ITR, PCP or lack of Discharge/Transition Plan and a new comprehensive clinical assessment (when applicable) will result in a request being "unable to process".

I. The recipient's expected discharge date from the following service is:

- Residential Level III Expected Discharge Date: ___/___/___
- Residential Level IV Expected Discharge Date: ___/___/___

II. At time of discharge the recipient will transition and/or continue with the following services. Please indicate both the planned date of admission to each applicable service and the anticipated provider.

- Natural and Community Supports (Provide details in Section III.)
- Outpatient Individual Therapy ___/___/___ Provider: _____
- Outpatient Family Therapy ___/___/___ Provider: _____
- Outpatient Group Therapy ___/___/___ Provider: _____
- Medication Management ___/___/___ Provider: _____
- Respite ___/___/___ Provider: _____
- Intensive In-Home ___/___/___ Provider: _____
- Multisystemic Therapy ___/___/___ Provider: _____
- Substance Abuse Intensive Outpatient ___/___/___ Provider: _____
- Day Treatment ___/___/___ Provider: _____
- Level II Program Type ___/___/___ Provider: _____
- Therapeutic Foster Care ___/___/___ Provider: _____
- PRTF ___/___/___ Provider: _____
- Other ___/___/___ Provider: _____
- Other ___/___/___ Provider: _____
- Other ___/___/___ Provider: _____

III. The Child and Family Team has engaged the following natural and community supports to both build on the strengths of the recipient and his/her family and meet the identified needs.

Name/Agency _____	Role _____	Date: _____
Name/Agency _____	Role _____	Date: _____
Name/Agency _____	Role _____	Date: _____
Name/Agency _____	Role _____	Date: _____

IV. Input into the Person-Centered Plan developed by the Child and Family Team was received from the following (Check all that apply):

- Recipient
- Family/Caregivers
- Natural Supports
- Community Supports (e.g. civic & faith based organizations)
- Local Management Entity
- Residential Provider
- MH/SA TCM Provider
- Court Counselor
- School (all those involved)
- Social Services
- Medical provider
- Other _____

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Consumer Name _____ Service Record # _____

V. Please explain your plan for transition to new services and supports (i.e. engaging natural and community supports, identification of new providers, visits home or to new residence, transition meetings with new providers, etc.) Who will do what by when?

Activity _____ ResponsibleParty _____ ImplementationDate _____

VI. The Child and Family Team updated the Crisis Plan as part of the PCP Revision to include issues of safety at home, at school and in the community.

Yes No

Please explain: _____

VII. For recipients identified as high risk for dangerous or self injurious behaviors the discharge/transition plan includes admission to the appropriate level of care.

Yes No

Please explain: _____

VIII. The Child and Family Team has identified and addressed the following potential barriers to success of the discharge/transition plan.

IX. The Child and Family Team will meet again on ___/___/___ in order to follow-up on the discharge/transition plan and address potential barriers.

X. Required Signatures

Recipient _____ Date ___/___/___

Legally Responsible Person _____ Date ___/___/___

Qualified Professional _____ Date ___/___/___

(Person responsible for the PCP)

- I agree with the Child and Family Team recommendation.
- I do not agree with the Child and Family Team recommendation.

(*Please note signature below is required by SOC regardless of agreement with recommendation. Signature does not indicate agreement or disagreement of Child and Family Team recommendation, merely review of discharge plan.)

LME SOC/Representative _____ Date ___/___/___

(Required for residential requests only)



_____ 'S PERSON-CENTERED PROFILE

Name:	DOB: / /	Medicaid ID:	Record #:
(Non - CAP-MR/DD Plans ONLY) PCP Completed on: / /	(CAP-MR/DD Plans ONLY) Plan Meeting Date: / / / /	Effective Date:	

WHAT PEOPLE LIKE AND ADMIRE ABOUT....

Empty text area for 'WHAT PEOPLE LIKE AND ADMIRE ABOUT....'

WHAT'S IMPORTANT TO....

Empty text area for 'WHAT'S IMPORTANT TO....'

HOW BEST TO SUPPORT....

Empty text area for 'HOW BEST TO SUPPORT....'

ADD WHAT'S WORKING / WHAT'S NOT WORKING

Empty text area for 'ADD WHAT'S WORKING / WHAT'S NOT WORKING'

Name:

DOB:

Medicaid ID:

Record #:

CRISIS PREVENTION AND INTERVENTION PLAN

(Use this form or attach your crisis plan.)

Significant event(s) that may create increased stress and trigger the onset of a crisis. (Examples include: Anniversaries, holidays, noise, change in routine, in ability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies that were effective. (List everything that can be done to help this person **AVOID** a crisis):

Strategies for crisis response and stabilization. (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

Describe the systems prevention and intervention back-up protocols to support the individual. (i.e. Who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible.)

Specific recommendations for interacting with the person receiving a Crisis Service:

Name: _____ DOB: _____ Medicaid ID: _____ Record #: _____

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes No

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: _____ Date: ____/____/____
(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ Date: ____/____/____
(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: _____ Date: ____/____/____
(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

- Met with the Child and Family Team - Date: ____/____/____
 - OR** Child and Family Team meeting scheduled for - Date: ____/____/____
 - OR** Assigned a TASC Care Manager - Date: ____/____/____
 - AND** conferred with the clinical staff of the applicable LME to conduct care coordination.
- If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:
 This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ Date: ____/____/____
(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: **REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.**

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual). My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. Yes No
- The licensed professional who signs this service order has reviewed the individual's assessment. Yes No

Signature: _____ License #: _____ Date: ____/____/____
(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order.

Signature: _____ License #: _____ Date: ____/____/____
(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: ____/____/____

Other Team Member (Name/Relationship): _____ Date: ____/____/____

Reproduce this form as needed.

**North Carolina Department of Cultural Resources
Division of Historical Resources
Government Records Branch**

REQUEST FOR DISPOSAL OF UNSCHEDULED RECORDS

TO Assistant Records Administrator
N.C. Division of Historical Resources
Government Records Branch
4615 Mail Service Center
Raleigh, NC 27699-4615

FROM Name _____
County _____
Agency or department _____
Phone number _____

In accordance with the provisions of G.S. 121 and 132, approval is requested for the destruction of records listed below. These records have no further use or value for official or administrative purposes.

RECORDS TITLE	DESCRIPTION	INCLUSIVE DATES	QUANTITY	MICROFILMED? (YES OR NO)	RETENTION PERIOD

Requested by: _____
Signature Title Date

Approved by: _____
Signature Mayor/Head of Governing Board Date

Concurred by: _____
(as indicated) Signature Assistant Records Administrator Date
NC Division of Historical Resources

APPENDIX B

SAMPLE FORMS

Sample Service Notes [generic]

Sample Service Note A

Sample Service Note B

Sample Service Note C

Sample Service Note D

Other Sample Notes [for certain services]

Sample Grid Form and Instructions for Using a Grid, Including the Sample Grid

Sample Form for PSR Note

Name:	<ol style="list-style-type: none"> 1. Date of Service 2. Identification of Recipient – if different from the client 3. Purpose of Contact
Medicaid ID Number:	<ol style="list-style-type: none"> 4. Description of Intervention(s) 5. Effectiveness of the Intervention(s)
Record Number:	<ol style="list-style-type: none"> 6. Duration of the Service - All periodic, as required by the specific service, or as otherwise required 7. Professional Signature - Degree, credentials, or licensure Paraprofessional Signature – Position
<p style="font-size: 48px; opacity: 0.2; transform: rotate(-30deg);">FINAL DRAFT</p>	

NAME:		MEDICAID ID #:	RECORD NUMBER:
Date	Duration	Instructions: Briefly state purpose of contact, describe the intervention(s), and the effectiveness of the intervention(s).	*Full Signature Required
		PURPOSE OF CONTACT:	
		DESCRIPTION OF THE INTERVENTION(S):	
		EFFECTIVENESS OF THE INTERVENTION(S):	
		PURPOSE OF CONTACT:	
		DESCRIPTION OF THE INTERVENTION(S):	
		EFFECTIVENESS OF THE INTERVENTION(S):	
		PURPOSE OF CONTACT:	
		DESCRIPTION OF THE INTERVENTION(S):	
		EFFECTIVENESS OF THE INTERVENTION(S):	
		PURPOSE OF CONTACT:	
		DESCRIPTION OF THE INTERVENTION(S):	
		EFFECTIVENESS OF THE INTERVENTION(S):	

* For *professionals* - signature, credentials, degree or licensure; for *paraprofessionals* - signature and position

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Service Notes

Individual:		Medicaid ID#:	Record Number:
Date:		*Shift/Duration of Service:	
Purpose of Contact:			
Intervention(s) [what you did]:			
Effectiveness of the Intervention(s):			
*Full Signature Required			
Date:		*Shift/Duration of Service:	
Purpose of Contact:			
Intervention(s) [what you did]:			
Effectiveness of the Intervention(s):			
*Full Signature Required			
Date:		*Shift/Duration of Service:	
Purpose of Contact:			
Intervention(s) [what you did]:			
Effectiveness of the Intervention(s):			
*Full Signature Required			

* For professionals – signature, credentials, degree or licensure; for paraprofessional - signature & position

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Note: This sample grid may only be used for Behavioral Health Prevention Education Services in Selective and Indicated Populations, Residential Treatment – Family Type [Level II], Personal Care [IDD], Respite [except for Institutional Respite], and the following NC Innovations services: Community Networking, Day Supports, In-Home Skill Building, Personal Care, and Supported Employment Services.

Name of Individual: _____ Medicaid ID#: _____ Record #: _____ Month/Year: _____

Specify Service:	LME/MCO:	Service Provider/ Agency:														
Goals	Key	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	(I)															
	(A)															
	(I)															
	(A)															
	(I)															
	(A)															
Duration [when required]:																
Date:																
Initials:																

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Note: This sample grid may only be used for Behavioral Health Prevention Education Services in Selective and Indicated Populations, Residential Treatment – Family Type [Level II], Personal Care [IDD], Respite [except for Institutional Respite], and the following NC Innovations services: Community Networking, Day Supports, In-Home Skill Building, Personal Care, and Supported Employment Services.

Name of Individual: _____ Medicaid ID#: _____ Record #: _____ Month/Year: _____

Specify Service: _____ LME/MCO: _____ Service Provider/ Agency: _____

Goals	Key	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	(I)																
	(A)																
	(I)																
	(A)																
	(I)																
	(A)																
Duration [when required]:																	
Date:																	
Initials:																	

APPENDIX B

INSTRUCTIONS FOR USING A GRID, INCLUDING THE SAMPLE GRID

Required Elements of a Service Grid

When a grid is used to document a service, it shall be completed per event, or at least per date of service, to reflect the service provided. Any service grid, whether using the sample grid format contained in this appendix, or another grid format, shall include all the following required elements:

1. Name of the individual
2. The service record number, Medicaid ID number (as applicable), or unique identifier
3. Full date [month/day/year] that the service was provided
4. Name of the service being provided [e.g., Personal Care Services]
5. Goals addressed
6. A number or letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed
7. A number or letter as specified in the appropriate key that reflects the assessment of the individual's progress toward goals
8. Duration
9. Initials of the individual providing the service. The initials shall correspond to a full signature and initials on the signature log section of the grid.
10. A comment section for entering additional or clarifying information, e.g., to further explain the interventions/ activities provided, or to further describe the individual's response to the interventions provided and progress toward goals. Each entry in the comment section must be dated.

Services That May Be Documented on a Grid

The use of a service grid is limited to the following services:

- Behavioral Health Prevention Education Services in Selective and Indicated Populations;
- Child and Adolescent Residential Treatment – Level II – Family Type;
- Community Networking [NC Innovations];
- Day Supports [NC Innovations];
- In-Home Intensive Supports [NC Innovations];
- In-Home Skill Building [NC Innovations];
- Personal Care [NC Innovations] (This service may be documented using a combination of a grid/checklist and a modified service note, unless provided by a home care agency that is following home care licensure rules.);
- Personal Care Services [I/DD] (This service may be documented using a combination of a grid/checklist and a modified service note, unless provided by a home care agency that is following home care licensure rules.);
- Residential Supports [NC Innovations];
- Respite (all categories, except for Institutional Respite, which shall follow the State Developmental Centers' documentation requirements. Respite may be documented on a modified service note, a service grid, or a combination of the two. SPECIAL NOTE: For Community Respite [YP730], if using a service grid, documentation is required per date of service. If using a modified service note, or a combination of a modified note and a service grid, documentation frequency is per date of service, if the duration of the service was no longer than a day. If longer than a day, documentation shall be for the duration of the event, but not less than weekly.); and
- Supported Employment Services [NC Innovations].

Purpose: The purpose of a grid is to provide a means of quickly capturing the goal(s) addressed, the staff's intervention/activities and the assessment of the individual's progress toward the goals established.

In addition to the required elements listed above [1-10], the following guidelines should be followed when using a grid:

1. **Page ___ of ___:** The number of sheets that will be needed per 15/16-day cycle will depend on how many goals the individual has in the service plan.
2. **Month/Year:** Enter the month and year for service coverage.
3. **Shift:** When appropriate, enter the shift for which the entries represent.
4. **LME-MCO:** Enter the name of the LME-MCO.
5. **Service Provider/Agency:** If the service is provided by an agency other than the LME-MCO, enter the name of the provider/agency.
6. **Goal(s):** Enter the goal as stated in the individual's service plan. The goal should be written as documented in the service plan.
7. **Key:** A key(s) utilizing letters shall be developed to reflect interventions/activities. A key(s) utilizing numbers shall be developed to reflect the assessment of the individual's progress toward the goals. All keys developed shall be identified in a Key Menu.

On the grid in the Key box, identify in the top part of the box labeled, "I", the key to be used to reflect the interventions/activities. On the bottom part labeled, "A", the key is used to reflect the assessment of the individual's progress toward the goals.

8. **Numbered Boxes 1-15/16-31:** Each numbered box represents a day of the month. The number of boxes used will depend on how many days are in that particular month. Each box is divided into an upper half and a lower half. The top half of the box represents the intervention/activity provided - [noted as an "I" in top half of the key section], and the lower half [noted as an "A"] represents the assessment of the individual's progress toward the goals. Based upon the key identified in the Key box, assign a letter that represents the intervention/activity provided and a number that represents the assessment of the individual's progress toward goals. A number can be placed in front of the key used to signify how many interventions/activities the staff provided.
9. **Duration:** Enter the total amount of time spent performing the intervention(s).
10. **Date:** Enter the date the documentation is initiated for services provided to the individual.
11. **Initials:** The provider shall enter his or her initials for each day he or she provides a service to the individual. The initials shall correspond to the section on the back of the form called, "All Staff Persons Working with This Individual Must Fill Out the Information Below."
12. **Comments:** Each entry shall be dated. This section is for entering additional or clarifying information, e.g., to further explain the interventions/activities provided or to further describe the individual's response to the interventions provided and progress toward goals.
13. **All Staff Persons Working With This Individual Must Fill Out The Information Below:** A staff person working with the individual shall complete this section, which includes the staff person's printed name, full signature, and initials.

Psychosocial Rehabilitation [PSR] Notes

Name of Individual: _____ Medicaid ID Number: _____ Record Number: _____

Date:	Duration - Time spent performing the interventions:	Instructions: Briefly state purpose of contact, description of intervention/activity, and the effectiveness of the intervention/activity.	Staff Signature/Position [full signature required]
		<p>Purpose of Contact: [Individual's goals may be pre-printed here.]</p> <p>The following Interventions/Activities were provided to the member and participation was encouraged, monitored and/or modeled by staff: <input type="checkbox"/> Pre-vocational <input type="checkbox"/> Recreation/Leisure <input type="checkbox"/> Community Living <input type="checkbox"/> Social Relationships <input type="checkbox"/> Educational <input type="checkbox"/> Personal Care/Daily Living <input type="checkbox"/> Other _____</p> <p>Effectiveness of the Interventions:</p>	
		<p>Purpose of Contact: [Individual's goals may be pre-printed here.]</p> <p>The following Interventions/Activities were provided to the member and participation was encouraged, monitored and/or modeled by staff: <input type="checkbox"/> Pre-vocational <input type="checkbox"/> Recreation/Leisure <input type="checkbox"/> Community Living <input type="checkbox"/> Social Relationships <input type="checkbox"/> Educational <input type="checkbox"/> Personal Care/Daily Living <input type="checkbox"/> Other _____</p> <p>Effectiveness of the Interventions:</p>	

APPENDIX C

SERVICE SPECIFIC FORMS

Alcohol Use Disorders Identification Test (AUDIT)
Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)
Drug Abuse Screening Tool (DAST-10)
Emotional Health Inventory (EHI™)
Substance Abuse Behavioral Indicator Checklist II
[Sample] Tuberculosis Screening Instrument for Infectious Tuberculosis

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Please Note: Alcohol is inclusive of: beer, wine, liquor or any other alcoholic beverage.

- How often do you have a drink containing alcohol?
(0) Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week
- How many drinks contain alcohol do you have on a typical day when you are drinking?
(0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10 or more
- How often do you have six or more drinks on one occasion?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
- How often during the last year have you found that you were unable to stop drinking once you started?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
- How often during the last year have you failed to do what was normally expected of you because of drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
- How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
- How often during the last year have you felt guilt or remorse after drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
- How often during the last year have you been unable to remember what happened the night before because of drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
- Have you or someone else been injured as a result of your drinking?
(0) no (2) yes, but not in the last year (4) yes, during the last year
- Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
(0) no (2) yes, but not in the last year (4) yes, during the last year

Total Score: _____

[Saunders JB, Aasland OG, Babor TF *et al.* Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption]

SCORING THE AUDIT

Scores for each question range from 0 to 4, with the first response for each question (e.g. never) scoring 0, the second (e.g. less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more meets the criteria for a positive screen, refer the individual to the Qualified Professional Substance Abuse for further assessment.

(Refer an **individual under age 21** with a score of 1 or more to the Qualified Professional Substance Abuse for further assessment.)

DSS-8218 (rev. 08-2015)

Economic and Family Services Section

The North Carolina Division of Social Services does not discriminate against any person on the basis of race, color, natural origin, sex, age, religion, political beliefs, or disability in the admission, treatment, or participation in its programs, services and activities, or in employment.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ **Date:** _____ **Time:** _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____ **Blood pressure:** _____

<p>NAUSEA AND VOMITING – Ask “Do you feel sick to your stomach? Have you vomited?” Observation. 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting</p>	<p>TACTILE DISTURBANCES – Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?” Observation. 0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>
<p>TREMOR – Arms extended and fingers spread apart. Observation. 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient’s arms extended 5 6 7 severe, even with arms not extended</p>	<p>AUDITORY DISTURBANCES – Ask “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?” Observation. 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>
<p>PAROXYSMAL SWEATS – Observation. 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats</p>	<p>VISUAL DISTURBANCES – Ask “Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” Observation. 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>
<p>ANXIETY – Ask “Do you feel nervous?” Observation. 0 no anxiety, at ease 1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</p>	<p>HEADACHE, FULLNESS IN HEAD – Ask “Does your head feel different? Does it feel like there is a band around your head?” Do not rate for dizziness or lightheadedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe</p>
<p>AGITATION – Observation. 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about</p>	<p>ORIENTATION AND CLOUDING OF SENSORIUM – Ask “What day is this? Where are you? Who am I?” 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place or person</p>

Total **CIWA-Ar** Score _____
 Rater’s Initials _____
 Maximum Possible Score 67

The **CIWA-Ar** is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

DRUG ABUSE SCREENING TOOL (DAST-10)

1982 by the Addiction Research Foundation. Author: Harvey A. Skinner Ph.D.

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

- | | | |
|---|-----|----|
| 1. Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. Do you abuse more than one drug at a time? | Yes | No |
| 3. Are you always able to stop using drugs when you want to? | Yes | No |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | Yes | No |
| 5. Do you ever feel bad or guilty about your drug use? | Yes | No |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 7. Have you neglected your family because of your use of drugs? | Yes | No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? | Yes | No |

Score: _____ (A score of 3 or more, refer the individual for Work First Program Substance Use Testing.)

SCORING THE DAST-10

For the DAST-10, score 1 point for each question answered "yes," except for Question 3 for which a "no point" receives 1.

DAST-10 INTERPRETATION

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	none at this time
1-2	Low level	monitor, re-assess at a later date
3-5	Moderate level	further investigation
6-8	Substantial level	intensive assessment
9-10	Severe level	intensive assessment

Applicant/Recipient Name _____ Date _____

E H I – 13

Emotional Health Inventory – 13 Item Version

Administration Guide

Introduction

These questions are designed to assess risk for some common mental health conditions. The items cover depression, mania, anxiety, obsessive-compulsive disorder, and posttraumatic stress disorder. This is by no means a comprehensive screen of all possible conditions. The objective is to identify some of the more prevalent conditions. Individuals providing positive responses indicating current emotional problems should be assessed by an appropriate professional.

Although the following questions cover content related to making diagnoses, this instrument is not a diagnostic tool. The purpose of these items is to assist in identifying those individuals who may have an emotional condition that could interfere with their ability to secure and maintain employment.

Administration

Under NO circumstance should the client be allowed to fill out the form.

This questionnaire is intended to be verbally presented. Read the directions and the first 12 numbered questions as written to the respondent. Only if the respondent answers “yes” to any of the first 12 questions should question 13 be asked.

One of the reasons for a verbal screening is to avoid reading or learning difficulties. Individuals with reading problems are often very ingenious in masking their disability. We want to be sure that the respondent understands the item and is not simply checking off answers.

The instructions and all of the numbered questions should be read to the respondent exactly as they are written. Do not reword any of the items when you read them. Only if the client indicates that she, or he, does not understand the item or a particular word should you attempt to assist the client by providing any synonym for a word or definition of a term.

Referral

If the respondent answers “yes” to one or more of the first 12 questions and to the last one; thus indicating a potential current problem, she, or he, should be referred for further evaluation. You should indicate the specific item(s) endorsed by the respondent in making the referral. If no problem is current, no referral should be made.

EHI™

EMOTIONAL HEALTH INVENTORY – 13 Item Version

Norman G. Hoffmann, Ph.D. & Todd W. Estroff, M.D.

Name: _____

ID#: _____

Interviewer: _____

Date of Birth: ____ / ____ / ____
month day year

Current Date: ____ / ____ / ____
month day year

If you don't understand a question please let me know.

Some of the questions may sound unusual or strange, but I need to have an answer to each one.

NO YES

- ___ ___ 1. Has there ever been at least a two-week period when you felt depressed?
- ___ ___ 2. Have you ever had at least a two-week period when you lost interest in almost all enjoyable activities or were unable to get pleasure from almost anything?
- ___ ___ 3. Have you ever experienced more than several days when you felt unusually happy or "on top of the world" for no reason?
- ___ ___ 4. Has there been a period when you had so much energy that you were able to go for days with little or no sleep?
- ___ ___ 5. During any time did you find your thoughts racing or mixed up so you could hardly keep up with them?
- ___ ___ 6. Have you had distinct periods of intense fear or discomfort when there was no physical danger?
- ___ ___ 7. Do you worry about things or possible events even though others say there is no danger or problem?
- ___ ___ 8. Do you go out of your way to avoid situations, places, or things so that it interferes with your life?
- ___ ___ 9. Do you have repeated ideas, thoughts, or urges that bother you?
- ___ ___ 10. Do you need to do something special to make troubling ideas, thoughts, or urges go away?
- ___ ___ 11. Is there a past event or period of time that continues to bother you; and you can't get it out of your mind?
- ___ ___ 12. Do you experience any ideas or memories that bother you and keep coming back even though you don't want to think about them?

If any of the above are answered "yes", ask the following question:

- ___ ___ 13. Of the previous items, have any of them occurred in the last 3 months?

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Smithfield, RI 401-231-2993

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Figure 104B- 3

**SUBSTANCE ABUSE
BEHAVIORAL INDICATOR CHECKLIST II**

This form may be completed if a Work First client has a negative screening for substance abuse, but there is reasonable suspicion that substance abuse issues may be present. When there is an observation of actions, appearance or conduct that may be associated with substance abuse issues refer the Work First client to a Qualified Substance Abuse Professional (WF/QSAP) for further assessment and/or referral.

Name of Client: _____
 Name of Observer: _____
 Location: _____

Date Observed: _____
 Time of Observation: _____ a.m./p.m.

Check all appropriate items. Behavioral indicators require only one check for referral to a WF/QSAP.

APPEARANCE/PHYSICAL SYMPTOMS:

- odor of alcoholic beverage on breath
- extremely poor hygiene
- constricted pupils (pinpoint)
- dilated pupils (enlarged)
- glazed or glassy eyes
- stumbling/staggering
- body odor of alcoholic beverage
- lethargic/slow movement
- swaying gait

HISTORY OF SUBSTANCE ABUSE RELATED PROBLEMS:

- pending DWI court case or drug court case
- loss of license for DWI
- drug or alcohol arrest or conviction
- history of or current substance abuse treatment involvement
- reports from employer, probation/parole of positive drug screen/breathalyzer
- positive AUDIT or DAST and non-Compliance with referral to QSAP
- prior SUDDS-V diagnosis and non-compliance with treatment recommendations

SPEECH:

- slurred speech
- rapid/accelerated speech
- incoherent speech

CONDUCT/BEHAVIOR:

- loss of inhibitions with no apparent reason (i.e., yelling, screaming, cursing, assaultive)
- failure to report for job interview (2 or more)
- repeated missed scheduled appointments

If known, how is the Work First client's behavior different from that previously observed? Be specific and describe any other observations about behaviors or actions not listed above:

To the best of my knowledge, this report represents the appearance, behavior and/or conduct of the above named Work First client, observed by me and upon which I base my decision to refer the person to the WF/QSAP for further assessment and/or referral.

 Signature of Observer

Date: _____

To be completed by WF/QSAP:

Was SUDDS V completed?
 Was Work First client referred to SA treatment?

Yes _____ No _____
 Yes _____ No _____

WF/QSAP Signature _____

Date: _____

SAMPLE SCREENING INSTRUMENT FOR INFECTIOUS TUBERCULOSIS

	Yes	No	Comments
1. Has it been more than three (3) months since you've seen a doctor or other health care provider?			
2. Have you or do you now live in a shelter or on the streets?			
3. Have you been in jail or prison in the past year?			
4. Has it been more than one (1) year since you've had a TB skin test? What were the results?			
5. Have you ever been told you have TB?			
6. Have you ever been treated for TB?			
7. Within the past thirty days have you had any of the following symptoms for two (2) or more weeks:			
• Fever			
• Drenching night sweats (See Guidance page for qualifications.)			
• Productive cough			
• Coughing up blood			
• Shortness of breath			
• Lumps or swollen glands in the neck or armpits			
• Unexplained weight loss [losing weight without meaning to]			
• Diarrhea lasting more than a week			
8. Has anyone you know or lived with been told they have TB in the past year?			
9. Do you live with anyone who has had either of these symptoms: coughing up blood or drenching night sweats?			

Signature

Date

GUIDANCE FOR COMPLETING SAMPLE SCREENING INSTRUMENT FOR INFECTIOUS TUBERCULOSIS - GUIDANCE

The following questions in this screening instrument are worded so that an answer of “yes” indicates an increased risk of infection of tuberculosis. Referral to a local health department should be made when an increased risk is identified. Following each question is background information pertaining to the question and the rationale for its conclusion.

1. Has it been more than three (3) months since you've seen a doctor or other health care provider?
(This question is a lead-in intended to put the interviewee at ease.)
2. Have you or do you now live in a shelter or on the streets?
(This question is asked because there is an increase in the incidence of TB among homeless individuals that is related to their crowded conditions and limited access to medical care.)
3. Have you been in jail or prison in the past year?
(In certain areas, there is an increased risk of TB exposure among individuals who have been incarcerated. This is related to crowded conditions and to the common occurrence of sexual assault among prison inmates.)
4. Has it been more than one (1) year since you've had a TB skin test? What were the results?
(This question is intended to identify individuals with latent TB who are, as a consequence, at risk for active TB. Although most individuals with positive TB skin tests do not have active TB, individuals in outreach populations who have been screened previously and found to have positive skin tests should be referred for evaluation to determine whether they have active TB or should receive preventive chemotherapy.)
5. Have you ever been told you have TB?
(This question is intended to identify individuals with TB who are not already in contact or have fallen out of touch with their treatment facility. In the non HIV- infected population, the highest risk of developing active TB occurs within the first year after exposure and infection. In the HIV- infected population, however, development of active disease does not diminish dramatically with subsequent years.)
6. Have you ever been treated for TB?
(This question is intended to determine if an individual has ever tested positive for and been treated for active TB.)
7. Within the past thirty days have you had any of the following symptoms for two (2) or more weeks: fever; drenching night sweats that were so bad you had to change your clothes or sheets on the bed; productive cough; coughing up blood; shortness of breath; lumps or swollen glands in the neck or armpits; unexplained weight loss (losing weight without meaning to); diarrhea lasting more than a week?
(Although the first four symptoms above are common among individuals with active TB, they are nonspecific and are consistent with other diagnoses, including bacteria pneumonia, acute bronchitis, cancer of the lung, HIV-related lung disease, and others. Other symptoms include lumps or swollen glands in the neck or armpits, which may be present in individuals with Extrapulmonary TB or AIDS-related conditions. Unintentional weight loss may identify individuals with latent or active TB or HIV infection; these are very nonspecific symptoms, however, and multiple other diagnoses are possible. Diarrhea lasting more than a week may identify persons with HIV infection but is also nonspecific.)

8. Has anyone you know or lived with been told they have TB in the past year?
(This question is intended to identify individuals who may be in contact with someone who has TB.)
9. Do you live with anyone who has had either of these symptoms: coughing up blood or drenching night sweats?
(This question is intended to identify individuals who have been in contact with someone who has TB and who thereby have an increased risk of developing latent or active TB. These symptoms have been selected from those in number 7 as being somewhat more specific and more likely to indicate a high degree of infectious risk.)

FINAL DRAFT

APPENDIX D

Behavioral Health Prevention Education Services for Children and Adolescents in
Selective and Indicated Populations

Webpage Links

Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations

Behavioral Health Prevention Education Services for children and adolescents who meet eligibility for selective and indicated population criteria are designed to prevent or delay the first use of substances, or to reduce or eliminate the use of substances. This service is provided in a group modality and is intended to meet the substance abuse prevention and/or early intervention needs of participants with identified risk factors for substance abuse problems [Selective] and/or with identified early problems related to substance use [Indicated]. Participants in Behavioral Health Prevention Education Services have identified risk factors or show emerging signs of use and the potential for substance abuse. The most typical program has a provider working directly with participants or parents [in a group setting] in a wide variety of settings including naturally occurring settings [school or community, etc.] on reducing known risk factors and/or enhancing protective factors that occur in that setting. Services are designed to explore and address the individual's behaviors or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of substance use. This service includes education and training of caregivers and others who have a legitimate role in addressing the risk factors identified in the service plan. This service includes, but is not limited to, children of substance abuser groups, education services for youth, parenting/family management services, peer leader/helper programs, and small group sessions. This service is preventive in nature and is not intended for individuals who have been determined to have a diagnosable substance abuse or mental health disorder which requires treatment. This service is time-limited, based on the duration of the curriculum-based program used. A provider is required to utilize an evidenced-based program in one of three nationally-approved categories: Promising Programs, Effective Programs, and Model Programs.

The Behavioral Health Prevention Education Services documentation shall be required for all children and adolescents receiving substance abuse selective and indicated prevention services and shall meet the following minimum requirements:

- **Documentation of Child and Adolescent Risk Profile:** Documentation of the findings of a child or adolescent risk profile that identifies one or more risk factors for substance abuse.
- **Assessment and Plan:**
 1. The Assessment of the participant shall include:
 - a. Documentation of the findings on a child or adolescent risk profile that identifies one or more designated risk factors for substance abuse;
 - b. Documentation of individual risk factor(s), history of substance use, if any, a description of the child's or adolescent's current substance use patterns, if any, and attitudes toward use; and
 - c. Other relevant histories and mental status that are sufficient to rule out other conditions suggesting the need for further assessment and/or treatment for a substance abuse or dependence diagnosis and/or a co-occurring psychiatric diagnosis.
 2. The Plan shall:
 - a. Be based on an identification of the child's, adolescent's, and/or family's problems, needs, and risk factors, with recognition of the strengths, supports, and protective factors;
 - b. Match the child or adolescent risk profile with appropriate evidence-based Selective or Indicated Substance Abuse Prevention goals that address the child's or adolescent's and/or family's knowledge, skills, attitudes, intentions, and/or behaviors; and
 - c. Be signed by the participant and the parent/guardian, as appropriate, prior to the delivery of services.
 3. Following the delivery of each service, the minimum standard for documentation in the service record shall be a Service Grid which includes:
 - a. Identification of the evidence-based program being implemented;
 - b. Full date and duration of the service that was provided;

- c. Listing of the individual child or adolescent and/or his or her family members that were in attendance;
- d. Identification of the curriculum module delivered;
- e. Identification of the module goal;
- f. Identification of the activity description of the module delivered;
- g. Initials of the staff member providing the service which shall correspond to a signature with credentials identified on the signature log section of the Service Grid; and
- h) In addition to the above, notation of significant findings or changes in the status of the child or adolescent that pertain to the appropriateness of provision of services at the current level of care and/or the need for referral for other services shall be documented.

- **Consent for Participation:** In all circumstances, the child or adolescent shall sign consent for participation in behavioral health prevention education services.
- **Service Grid:** A service grid shall include a notation following the delivery of each service and shall include the date and duration of the service that was provided, a listing of the individual child or adolescent and/or his or her family members that were in attendance, an identification of the evidence-based program module and service type, session goal, standard activity description, and initials of the staff member providing the service. The initials shall correspond to a signature with credentials identified on the signature log section of the service grid. Also to be documented, as appropriate, shall be a special notation of any child or adolescent significant findings or changes in status that pertain to the provision of services at the current level of care or the need for referral for other services.
- **Individual and Family Outcomes:** Documentation shall include the findings of the standardized pre-tests and post-tests associated with the evidence-based program being implemented, and the individual and/or family outcomes resulting from the program intervention.

Commented [TTD2]: This is already in the manual. Why is it here as well?

Links to webpages noted in *Records Management and Documentation Manual*:

10A NCAC 27

<http://ncrules.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services\Chapter%2027%20-%20Mental%20Health,%20Community%20Facilities%20and%20Services>

42 CFR (Public Health)

http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42tab_02.tpl

45 CFR

http://www.ecfr.gov/cgi-bin/text-idx?SID=424dc4200730108e6579ba89dfb16cfb&mc=true&tpl=/ecfrbrowse/Title45/45tab_02.tpl

APSM 10-5: Records Retention and Disposition Schedule – DMH/DD/SAS Provider Agency

http://archives.ncdcr.gov/Portals/26/PDF/schedules/schedules_revised/Local_Provider.pdf

APSM 10-6: Records Retention and Disposition Schedule – DMH/DD/SAS Local Management Entity (LME)

http://archives.ncdcr.gov/Portals/26/PDF/schedules/schedules_revised/Local_Management_Entity.pdf

APSM 30-1, Rules for MH/DD/SA Facilities and Services

https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/apsm30-1_11-11_0.pdf

APSM 45-1, Confidentiality Rules

<http://www.ncdhhs.gov/document/apsm-45-1-confidentiality-rules>

APSM 95-2, Client Rights in Community Mental Health, Developmental Disabilities, and Substance Abuse Services

http://www.nasdds.org/uploads/documents/NC_apsm95-2clrights7-03.pdf

Behavioral Health Clinical Coverage Policies, 8-A through 8-P

<http://dma.ncdhhs.gov/document/behavioral-health-clinical-coverage-policies>

Child/Adolescent Discharge/Transition Plan

<https://ncdhhs.s3.amazonaws.com/s3fs-public/Child-Adolescent-Discharge-Plan-rev1-18-11.pdf>

DHHS Policy and Procedure Manual

<http://info.dhhs.state.nc.us/olm/manuals/manuals.aspx?dc=dhs>

DHHS Record Retention Policy, & Records Retention and Disposition Schedule for Grants

<http://www2.ncdhhs.gov/control/retention/retention.htm>

Division of Medical Assistance

<http://www.ncdhhs.gov/dma/prov.htm>

Division of Mental Health/Developmental Disabilities/Substance Abuse

<http://www.ncdhhs.gov/mhddsas/>

Division of MH/DD/SA Services Consumer Data Warehouse/LME Reporting Requirements

<http://www2.ncdhhs.gov/mhddsas/providers/reportingrequirements/cdwreportingrequirements2-11-08v110.pdf>

Division of Vocational Rehabilitation Services, documentation requirements

<https://www.ncdhhs.gov/document/vocational-rehabilitation-program-casework-and-service-delivery-policy>

EPSDT

<https://www.ncdhhs.gov/providers/provider-info/mental-health/early-periodic-screening-diagnostic-and-treatment-medicaid-services-for-children>

Government Records Section, NC Archives

<http://archives.ncdcr.gov/>

G.S. § 90-21.5

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.5.html

G.S. § 122C

<http://www.ncga.state.nc.us/qascripts/Statutes/StatutesTOC.pl?Chapter=0122C>

G.S. § 122C-223

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_122C/GS_122C-223.html

G.S. § 130A (Public Health)

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_130A.html

HIPAA Privacy and Security Rules (U.S. DHHS)

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html>

HIPAA web site

<http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/>

HIPAA – Use and Disclosure Policies

http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/Use_and_Disclosure_Use_and_Disclosure1.htm

Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985

http://www.ncleg.net/enactedlegislation/statutes/html/bychapter/chapter_122c.html

NCDHHS Child and Family Mental Health Services webpage (strengths-based assessment tool)

<http://www.ncdhhs.gov/providers/provider-info/mental-health/child-and-family-mental-health-services>

NC-SNAP

<http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-support-needs-assessment-profile>

NC System of Care Handbook for Children, Youth, and Families

<http://nccollaborative.poweredbyeden.com/files/647/27507.pdf>

NC-TOPPS

<http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system>

NC-TOPPS Implementation Guidelines, Appendix A

<https://nctopps.ncdmh.net/Nctopps2/docs/nc-toppsguidelinesjuly14.pdf>

NC-TOPPS Support Materials

<https://nctopps.ncdmh.net/dev/GettingStartedWithNCTOPPS.asp>

NC-TOPPS Web Portal

<https://nctopps.ncdmh.net/Nctopps2/Login.aspx>

NCTracks

<http://www.ncdhhs.gov/providers/provider-info/health-care/nctracks>

ONC Certified HIT product list

<https://www.healthit.gov/>

Person-Centered Planning

<http://www.ncdhhs.gov/document/person-centered-planning>

QM11 – Provider Quarterly Incident Report

<http://www.ncdhhs.gov/document/iris-resources>

Records Management – DMH/DD/SAS

<http://www.ncdhs.gov/mhddsas/providers/recordsmanagement/resources.htm>

State-Funded MH/DD/SA Service Definitions & Enhanced MH/SA Service Definitions

<http://www.ncdhs.gov/providers/provider-info/mental-health/service-definitions>

Supports Intensity Scale

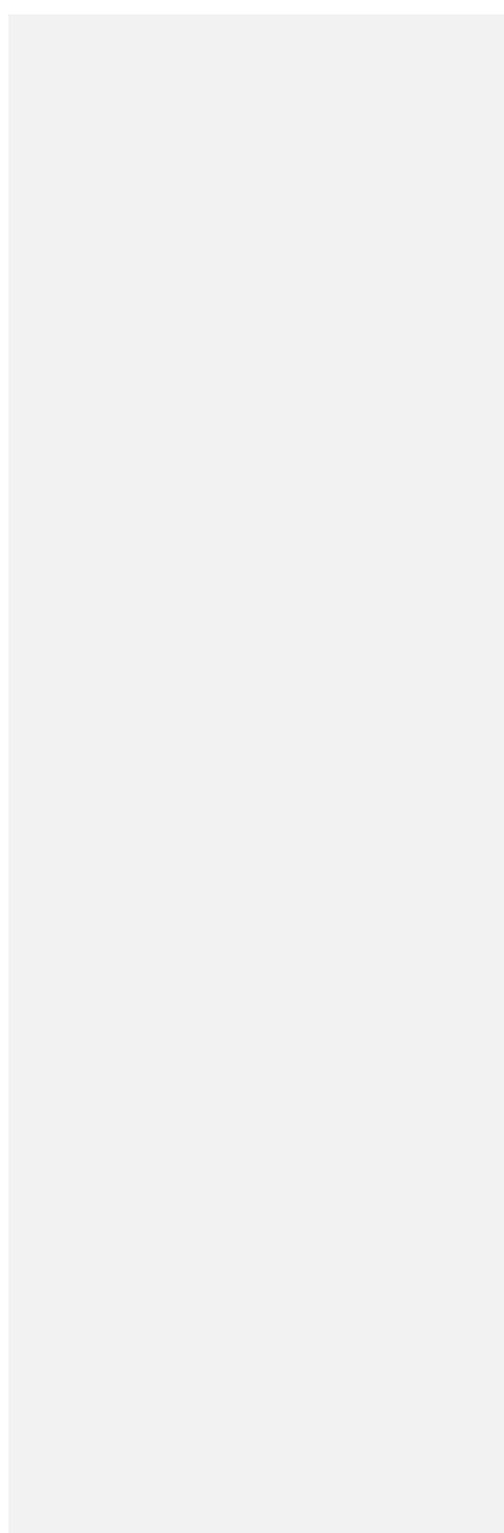
<http://www2.ncdhs.gov/ncinnovations/communications.html>

FINAL DRAFT

FINAL DRAFT

APPENDIX E

Glossary



Glossary

ACCESS - An array of treatments, services and supports is available; individuals know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION - Certification by an external entity that an organization has met a set of standards.

ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL [ADETS] - An approved curriculum which shall:

1. Include 10 to 13 contact hours in a classroom setting;
2. Be provided by area programs or their designated agencies with certified ADETS instructors; and
3. Be designed for persons:
 - a. who have only one DWI conviction [lifetime];
 - b. whose assessment did not identify a "Substance Abuse Handicap;" and
 - c. whose alcohol concentration was .14 or less.

AMERICAN SOCIETY OF ADDICTION MEDICINE [ASAM] PLACEMENT CRITERIA - The Patient Placement Criteria for the Treatment of Substance-Related Disorders produced by the American Society of Addiction Medicine. These criteria are used as guides for the provision of substance abuse treatment that is appropriate for the individual.

ARRAY OF SERVICES - Group of services available.

ASSESSMENT - A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability, or substance abuse treatment services and/or supports according to applicable requirements.

BASIC BENEFITS - Traditional behavioral health services under the Medicaid State Plan, including physician services, often referred to as outpatient treatment or medication management services, which include those services covered in Medicaid's *Clinical Coverage Policy 8C – Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*. These services may also be provided to individuals who meet medical necessity criteria for MH/IDD/SU Community Intervention Services, but for whom services are limited to outpatient and/or medication management services only.

BEST PRACTICE(S) - Interventions, treatments, services, or actions that have been shown to generate the best outcomes or results. The terms, "evidence-based" or "research-based" may also be used.

BLOCK GRANT - Funds received from the federal government [or others], in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. The Division of MH/DD/SAS receives three block grants: the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Social Services Block Grant.

CARE COORDINATION - Care coordination in the 1915(b)(c) waiver is specifically focused on the unique needs of individuals with mental health, substance use, and intellectual/developmental disabilities. Care Coordination in an LME-MCO provides the following supports to individuals:

- Education about all available mental health, intellectual or developmental disabilities, or substance use services and supports, as well as education about all types of Medicaid and state-funded services
- Linkage to needed psychological, behavioral, educational, and physical evaluations
- Development of the Individual Support Plan (ISP) or Person Centered Plan (PCP) in conjunction with the recipient, family, and other service and support providers
- Monitoring of the ISP, PCP, and health and safety of the individual
- Coordination of Medicaid eligibility and benefits.

CATCHMENT AREA - The geographic area of the state served by a specific LME-MCO.

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CENTERS FOR MEDICARE AND MEDICAID SERVICES [CMS] - The US federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program. This agency approves the North Carolina Medicaid Plan.

CLAIM - An itemized statement of services, performed by a provider network member or facility, which is submitted for payment.

COMMUNITY INTERVENTION SERVICE [CIS] AGENCY - Term used as a provider agency classification to confirm that the agency has met the eligibility criteria for entering into a participation agreement with the Division of Medical Assistance to provide certain specific services that have been endorsed or approved by the entity [the LME for MH/DD/SAS]

responsible for determining such eligibility. Once approval or endorsement has been awarded, the service provider agency may then achieve approved status as a Medicaid Provider of Community Intervention Services and enter into a participation agreement to provide the services.

COMMUNITY INTERVENTION SERVICES - Specific MH/IDD/SU services that are delineated in *Clinical Coverage Policy 8A* and subject to provider endorsement by the LME and direct enrollment with DMA for Medicaid-covered services.

COMPREHENSIVE CLINICAL ASSESSMENT - An intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that results in the issuance of a written report, providing the clinical basis for the development of a Person-Centered Plan [PCP] and recommendations for services/supports/treatment.

CONFIDENTIAL INFORMATION - Any information, whether recorded or not, relating to an individual served by a facility that was received in connection with the performance of any function of the facility. Confidential information does not include statistical information from reports and records or information regarding treatment or services shared for training, treatment, habilitation, or monitoring purposes that does not identify individuals either directly or by reference to publicly known or available information.

CONFIDENTIALITY - Keeping information private. Allowing records or information to be seen or used only by those with legal rights or permission.

CONSENT - Giving approval or agreeing to something. For example, in education, a parent must give consent before a child can be evaluated or placed in a special program. Consent is usually documented in writing and may be given for regular treatment, emergency medical care, and participation as a subject in a research project. The individual giving consent in a particular situation must have the legal authority to do so.

CONSENT FOR PARTICIPATION - A signed agreement to take part in treatment required for children and adolescents receiving substance abuse treatment.

CONSULTATION - Information shared between or among peers or professionals to increase the ability to manage challenging circumstances.

CONSUMER DATA WAREHOUSE [CDW] - A database containing data regarding demographic, clinical outcomes, and satisfaction data regarding individuals served by MH/IDD/SU service providers. The data stored in the CDW is the main source of information regarding block grant programs and to fulfill legislative requests. The information is also used for planning and evaluation of services.

CORE SERVICES - Services that are necessary for the basic foundation of any service delivery system. Core services under the Division of MH/DD/SAS are of two types: front-end service capacity, such as screening, assessment, triage, emergency services, service coordination, and referral; and indirect services, such as prevention, education, and consultation at a community level. Membership in a target population is not required to access a core service.

COUNTERSIGNATURE - Additional signatures, other than the signature of the individual who actually provided the service. Countersignatures are sometimes used to indicate the review and approval of documentation within the context of clinical supervision. Countersignatures are not required by the State, but countersignature entries in the service records may be required based upon the provider agency's policy when such a policy exists.

DAY/NIGHT SERVICES - Services provided on a regular basis, in a structured environment that is offered to the same individual for a period of three or more hours within a 24-hour period. This term generally refers to services that are a part of daily or regular group programming, but are not 24-hour residential services. Some examples of Day/Night Services are: Substance Abuse Intensive Outpatient Program, Day Treatment Programs and Partial Hospitalization, Developmental Day, Psychosocial Rehabilitation, ADVP, Supported Employment, Community Rehabilitation Program [Sheltered Workshop], and Day/Evening Activity.

DEPARTMENT OF HEALTH AND HUMAN SERVICES [DHHS] - The North Carolina agency that oversees state government human services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which:

1. is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;

3. is likely to continue indefinitely;
4. results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
5. reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated; or
6. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS [DSM-5] - Published by the American Psychiatric Association, the DSM-5 or any subsequent editions of this reference material is a classification and diagnostic tool consisting of special codes that identify and describe mental health, intellectual or developmental disabilities, and substance use disorders and their symptoms. The DSM-5 supersedes the DSM-IV-TR, and serves as a universal authority for psychiatric diagnoses.

DISCHARGE PLAN - A document generated at the time service is terminated that contains recommendations for further services designed to enable the person to live as normally as possible.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES [DMH/DD/SAS] - A division of the State of North Carolina, Department of Health and Human Services, responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DMA - The acronym for the North Carolina Division of Medical Assistance located in the Department of Health and Human Services. This is the agency that operates the Medicaid Program for North Carolina.

DRUG EDUCATION SCHOOL [DES] - A prevention and intervention service which provides an educational program for drug offenders as provided in the North Carolina Controlled Substances Act and Regulations.

DURATION - The total amount of time spent performing intervention(s). When applicable, this amount of time is documented in service notes and is billed within payor reimbursement guidelines for the service. Duration is required to be recorded:

- for all periodic services, unless the periodic service is billed on a per event basis;
- for all services as required by the Medicaid State Plan;
- for all services as required by Medicaid Clinical Coverage Policies; or
- whenever duration is required by the service definition.

EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES [EPSDT] - Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.

ELECTRONIC RECORD - A computer-based service record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data, alerts, reminders, clinical support systems, links to medical knowledge, and other aids. A record is not considered computer-based if it is only stored electronically in a computer as a word-processing file and not as a part of an electronic database.

ELECTRONIC SIGNATURE - A computer process whereby service documentation authorship and/or approval can be documented by a specific individual. Guidelines for electronic signature must be followed to ensure proper review of documentation, secure passwords, and individual documented agreement with the electronic signature guidelines.

EMPLOYEE ASSISTANCE PROGRAM [EAP] - A worksite-based program designed to assist: [1] work organizations in addressing productivity issues, and [2] employees in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance.

EVALUATION - More in-depth than an assessment, examination of specific needs or problems by professionals using specific evaluation tools.

EVIDENCE-BASED PRACTICE - Evidence Based Practice [EBP] refers to a research-based treatment approach or protocol that has been found to have clinical efficacy and effectiveness for individuals with certain emotional or behavioral challenges.

FIRST RESPONDER - The provider designated in the PCP to provide crisis response on a 24/7/365 basis. Typically, the first responder is the provider who has the most sustained contact and familiarity with the clinical dynamics of the individual being served.

FOLLOW-UP - A process of checking on the progress of a person who has completed treatment or other services, has been discharged, or has been referred to other services and supports.

GUARDIAN - An individual who has been given the legal responsibility to care for a child or adult who is incapable of taking care of themselves due to age or lack of capacity. The appointed individual is often responsible for both taking care of the child or incapable adult and their affairs. A legal guardian may provide permission for an individual to receive treatment. Also, a person appointed as a guardian of the person or general guardian by the court under Chapters 7A or 35A or former Chapters 33 or 35 of the General Statutes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT [HIPAA] - A federal Act that protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current recipient of services are not discriminated against based on health status. HIPAA also protects the privacy and security of an individual's protected health information.

HOME CARE AGENCY - An agency that is licensed by the Division of Facility Services [DFS] to provide home care services and directly-related medical supplies and appliances to an individual at his home. Home care services include nursing care; physical, occupational, or speech therapy; medical social services; "hands-on" in-home aide services; infusion nursing services; and assistance with pulmonary care, pulmonary rehabilitation, or ventilation.

INCIDENT AND DEATH REPORT - A report of any incident, unusual occurrence, medication error, or death of a person that occurs while an individual is under the care of a service provider. In order to maintain authorization to provide publicly-funded MH/IDD/SU services and good licensure status, a provider must follow the requirements for incident response and reporting as set forth in 10A NCAC 27G .0600, in accordance with Section 4.5 of NC Session Law 2002-164 [Senate Bill 163]. For full details on these requirements, consult the Administrative Code and the DHHS Incident and Death Reporting Form QM02 and Manual, which can be found under "Forms" at: <http://www.ncdhhs.gov/mhddsas/statpublications/manualsforms/index.htm>

INCIDENT RESPONSE IMPROVEMENT SYSTEM [IRIS] - A web based incident reporting system for reporting and documenting responses to Level II and III incidents involving consumers receiving mental health, developmental disabilities, and/or substance abuse services.

INDEPENDENT PRACTITIONER - A licensed practitioner who does not need to be endorsed by an LME and who may be directly enrolled with Medicaid to provide basic benefit services.

INDIVIDUALIZED EDUCATION PROGRAM [IEP] - A written plan for a child with special education needs. The plan is based on results from an evaluation and is developed by a team that includes the child's parents, teachers, other school representatives, specialists, and the child when appropriate.

INPATIENT - A person who is hospitalized. An inpatient facility may be hospital or non-hospital based, such as PRTF.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES [ICF/IID] - A facility that functions primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or persons with a related condition. It provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability.

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INTERNATIONAL CLASSIFICATION OF DISEASES [ICD-10-CM] - The International Classification of Diseases, Tenth Revision, Clinical Modification, US Department of Health and Human Services, US Government Printing Office, Washington, DC. This document provides diagnostic categorization and coding of illnesses.

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LEGALLY RESPONSIBLE PERSON - When applied to an adult, who has been adjudicated incompetent, a guardian; when applied to a minor, a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment; or when applied to an adult who is incapable as defined in G.S. 122C-72(c) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney as prescribed in Article 3 of Chapter 32 of the General Statutes.

LATE ENTRY - An entry in a service record that describes an event or episode of treatment that exceeds the allowable time frames for that documentation to be considered current. Please see Chapter 9 for specific guidance regarding allowable time frames per service type.

LICENSURE - A state or federal regulatory system for service providers to protect the public health and welfare. Examples of licensure include licensure of individuals by professional boards, such as the NC Psychology Board, or the NC Substance Abuse Professional Certification Board. Examples of licensure also include licensure of facilities used to provide MH/IDD/SU services by the NC Division of Facility Services.

LOCAL MANAGEMENT ENTITY [LME] - The local agency that plans, develops, implements, and monitors services within a specified geographic area, according to requirements of the Division of MH/DD/SAS. Includes developing a full range of services that provides inpatient and outpatient treatment, services, and/or supports for both insured and uninsured individuals.

LOCAL MANAGEMENT ENTITY / MANAGED CARE ORGANIZATION [LME-MCO] - The expansion in North Carolina of the functions of Local Management Entities [LMEs] to operate a Medicaid managed care program as a Managed Care Organization [MCO] for MH/IDD/SU services within their catchment area under a Medicaid waiver.

MANAGED CARE ORGANIZATION [MCO] - An organization contracted with the state to manage a health care delivery system designed to manage cost, utilization, and quality. Managed care initiatives are focused on improving care for populations with chronic and complex conditions, and building in accountability for high quality care.

MASTER INDEX - This index is a file of persons served. This list shall be permanently maintained manually or electronically by all service provider agencies.

MEDICAID - A jointly-funded federal and state program that provides hospital and medical expense coverage to low-income individuals, certain elderly people, and people with disabilities.

MEDICAL NECESSITY - Criteria established to ensure that treatment is necessary and appropriate for the condition or disorder for which the treatment is provided in order to meet the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual. In order for a service to be eligible for reimbursement by Medicaid or the State, the individual must have an established diagnosis reflecting the medical necessity criteria inherent in the service.

MEDICARE - A federal government hospital and medical expense insurance plan primarily for elderly people and people with disabilities.

MINOR [OR UNEMANCIPATED MINOR] - Any person under the age of 18 who has not been married or has not been emancipated pursuant to Article 35 of Chapter 7B of the General Statutes.

MODIFIED RECORD - A clinical service record which has requirements that are either different from those that are usually associated with a full clinical service record, or which contains only certain components of a full service record. The use of modified records is limited to those approved by DMH/DD/SAS, and used only if there are no other services being provided. When an individual receives additional services, then a full service record shall be merged into the full service record. Modified records may only be used for: Respite [if respite is the only service being provided]; Behavioral Health Prevention Education Services for Children & Adolescents in Selective and Indicated Prevention Services, Universal Prevention Services, and other services, if approved by the Division.

NORTH CAROLINA ADMINISTRATIVE CODE [NCAC] - State rules and regulations. The rules governing MH/IDD/SU services can be found in 10A NCAC, Chapters 26-31, linked here: <http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services> .

NCTRACKS - NCTracks is a multi-payer Medicaid Management Information System for the NC Department of Health and Human Services. It has three separate portals for specific internet access to different sectors of the business: providers, recipients, and internal operations needs.

NORTH CAROLINA TREATMENT OUTCOMES AND PROGRAM PERFORMANCE SYSTEM [NC-TOPPS] - Refers to the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services [DMH/DD/SAS] measures outcomes and performance for Substance Abuse and Mental Health service recipients. NC-TOPPS captures key information on a person's current episode of treatment, aids in evaluation of active treatment services, and provides data for meeting federal performance and outcome measurement requirements.

OUTCOMES - At the individual level, events used to determine the extent to which service recipients improve their levels of functioning, improve their quality of life, or attain personal life goals as a result of treatments, services and/or supports provided by the public and/or private systems. At the system level, outcomes are events used to determine if the system is functioning properly.

OVERSIGHT - Activities conducted by a government regulatory or funding agency [or other responsible agency] for the purpose of determining how a provider agency is functioning financially or programmatically. This includes LME activities related to provider endorsement and ongoing monitoring, service authorization, claims payment, and pre- and post-payment reviews. Oversight also includes audits, investigations, and other regulatory activities conducted by DMH/DD/SAS, DHSR, DMA, DSS, of other state agencies with responsibility for ensuring compliance with state and federal law, the quality of services, and/or the safety of consumers.

PENDING RECORD - A record that has the potential to become a full service record, once it is determined that the individual meets the requirements that call for the establishment of a full service record, and usually created when an individual presents for screening for possible services, or when there is insufficient, partial, or incomplete information available and a full service record cannot be established. A pending record may be used when there may have been some intervention, such as an initial screening, but the individual is not subsequently enrolled in active treatment. One service that is typically documented in a pending record include: Screening, Triage, and Referral; Court ordered consultation and/or evaluations that do not result in a subsequent MH/IDD/SU service; and Drop-In Center Services.

PERIODIC SERVICES - A service provided on an episodic basis, either regularly or intermittently, through short, recurring visits for persons with mental illness, developmental disabilities, or who are substance abusers.

PERSON-CENTERED PLANNING - An approach in which the individual directs his/her own planning process with the focus being on the expressed preferences, needs, and plans for his/her future. This process involves learning about the individual's whole life, not just the issues related to the person's disability. The process involves assembling a group of supporters, on an as-needed basis, who are selected by the individual with the disability and who have the closest personal relationship with them and are committed to supporting the person in pursuit of real life dreams. Those involved with the planning process are interested in learning who the person is as an individual and what he/she desires in life. The process is interested in identifying and gaining access to supports from a variety of community resources, one of which is the community NH/IDD/SU service system that will assist the person in pursuit of the life he/she wants. Person-centered planning results in a written individual support plan.

PERSON-CENTERED-PLAN - An individualized and comprehensive plan that specifies all services and supports to be delivered to the individual eligible for mental health and/or developmental disability and/or substance abuse services according to NC Mental Health Reform requirements. A person-centered plan generates action or positive steps that the person can take towards realizing a better and more complete life. Plans also are designed to ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to assess the quality of services being provided.

PREVENTION - Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing to mental illness, developmental disabilities and substance abuse. Universal prevention programs reach the general population; selective prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; indicated prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PRIOR AUTHORIZATION - A managed care process that approves the provision of services before they are delivered. ValueOptions performs prior authorization for Medicaid legal aliens; Medicaid children 0-3 years of age; Health Choice beneficiaries; and Medicaid admissions to Cumberland Hospital. Other Medicaid-funded services and state funded services that require prior authorization receive this from the LMEs.

PROTECTED HEALTH INFORMATION [PHI] - PHI is individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) payment for the provision of health care to an individual. If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information. See Part II, 45 CFR 164.501.

PROVIDER - A person or an agency that provides mental health, intellectual or developmental disabilities, and/or substance use services, treatment, supports.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM - The network of managing entities, service providers, government agencies, institutions, advocacy organizations, commissions and boards responsible for the provision of publicly-funded services to individuals.

QUALIFIED PROFESSIONAL - Any individual with appropriate training or experience in the fields of mental health, developmental disabilities, or substance abuse treatment as specified by the General Statutes or by rule.

Commented [BDE6]: Updated per Comment # 2

QUALIFIED PROVIDER - A provider who meets the provider qualifications as defined by rules adopted by the Secretary of Health and Human Services.

QUALITY ASSURANCE [QA] - A process to assure that services are minimally adequate, individual rights are protected, and organizations are fiscally sound. QA involves periodic monitoring of compliance with standards. Examples include: establishment of minimum requirements for documentation, service provision, licensure and certification of individuals, facilities, and programs; and investigation of allegations of fraud and abuse. See also, QUALITY MANAGEMENT.

QUALITY IMPROVEMENT [QI] - A process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business.

QUALITY MANAGEMENT [QM] - A framework for assessing and improving services and supports, operations, and financial performance. Processes include: quality assurance, such as external review of appropriateness of documentation, monitoring, and quality improvement, such as design and implementation of actions to address access. See also QUALITY ASSURANCE AND QUALITY IMPROVEMENT.

RECIPIENT - A person authorized for Medicaid or other program or insurance coverage. Also, an individual receiving a given service.

REFERRAL - The process of establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

SCREENING - An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for additional services. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it, whether or not they meet criteria for target or priority populations.

SCREENING, TRIAGE AND REFERRAL - This process involves a brief interview designed to first determine if there is a mental health, intellectual or developmental disabilities, or substance use service need, the likely area[s] of need, as well as the immediacy of need [emergent, urgent, or routine]. The individual is then connected to an appropriate provider for services based upon the area and level of need indicated.

SENSITIVE HEALTH INFORMATION - According to Community Partnership for eHealth, sensitive health information is information that carries with it unusually high risks in the event of disclosure. Disclosure risks include the possibility of discrimination, social stigma, and physical harm (for example, in the case of information linked to domestic violence or reproductive health). In 45 CFR Parts 160 and 164, a response to public comment on the (HIPAA Privacy Rule contains the following: "The Department treats all individually identifiable health information as sensitive and equally deserving of protections under the Privacy Rule." p. 53222
<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/privrule.txt>.

SERVICE GRID - A method of documentation of service provision that is approved for use for specific services.

SERVICE ORDER - Written authorization by the appropriate professional as evidence of the medical necessity of a given service.

SERVICE PROVIDER - Any person or agency giving some type of service to children or their families. A service provider, or service provider agency, is part of the provider community under Mental Health Reform.

SERVICE RECORD - A document that is required to demonstrate evidence of a documented account of all service provision to a person, including pertinent facts, findings, and observations about a person's course of treatment/habilitation and the person's treatment/habilitation history. The individual's service record provides a chronological record of the care and services which the individual has received and is an essential element in contributing to a high standard of care.

SERVICE RECORD NUMBER CONTROL REGISTER - This register controls the assignment of service record numbers. Any person admitted shall retain the same service record number on subsequent admission. This shall be permanently maintained manually or electronically by all service provider agencies.

STAFF - An employee of a governing body, provider agency, owner(s), individuals under contract with a provider agency, or individual behavioral health practitioners in a private practice.

STANDARDS - Activities generally accepted to be the best method of practice. Also, the requirements of licensing, certifying, accrediting, or funding groups.

STATE PLAN [DMH/DD/SAS] - The annually updated statewide plan that forms the basis and framework for MH/IDD/SU services provided across the state.

STATE PLAN [NORTH CAROLINA MEDICAID] - All of the formal policies, processes, and procedures approved by the US federal agency Centers for Medicare & Medicaid [CMS] regarding the Medicaid Program in North Carolina. This includes approval of Medicaid services and service definitions.

TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES [TASC] - A service designed to offer a supervised community-based alternative to incarceration or potential incarceration, primarily to individuals who are alcohol or other drug abusers, but also to individuals who are mentally ill or developmentally disabled and who are involved in crimes of a non-violent nature. This service provides a liaison between the criminal justice system and alcohol and other drug treatment and educational services. It provides screening, identification, evaluation, referral, and monitoring of alcohol or other drug abusers for the criminal justice system.

TWENTY-FOUR HOUR FACILITY - A facility wherein a service is provided to the same individual on a 24-hour continuous basis, and includes residential and hospital facilities.

UTILIZATION MANAGEMENT [UM] - A process to regulate the provision of services in relation to the capacity of the system and the needs of individuals. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of individuals. UM is typically an externally-imposed process, based on clinically defined criteria.

UTILIZATION REVIEW [UR] - An analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. UR is typically an internally-imposed process that employs clinically established criteria.