214-RICR-40-00-8

TITLE 214 - DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

CHAPTER 40 – LICENSING AND GENERAL ADMINISTRATION

Part 8 – Children's Behavioral Healthcare Organizations

8.1 GENERAL PROVISIONS

8.1.1 Applicability

A. These regulations are promulgated pursuant to R.I Gen. Laws Chapters 42-72, 42-72.1, 40-13.2, 40.1-8.5-8, 42-72.9, 5-39.1, and 42 USC § 201.

B. These regulations are promulgated pursuant to the authority conferred under the following regulations:

1. R.I. Gen. Laws § 42-72-5, Power and Scope of Activities of the Department of Children, Youth and Families (hereinafter, the Department) and are established for the purpose of adopting prevailing standards for the licensure and operation of programs providing behavioral health services for children.

2. R.I. Gen. Laws § 42-72.1, Licensing and Monitoring of Child Placing Agencies, Child Caring Agencies, Foster and Adoptive Homes, and Children's Behavioral Health Programs.

3. R.I. Gen. Laws § 42-72-5.2, Development of a Continuum of Children's Behavioral Health Programs. R.I. Gen. Laws § 42-72-15, Children's Bill of Rights.

C. These regulations apply to Organizations that provide services, programming, supports, and/or treatment for children with mental or behavior health conditions, including those children with serious emotional disturbances (SED) and children with an intellectual developmental disability (IDD), as defined by R.I. Gen. Laws § 42-72-5 for both SED and IDD referred to as "functional developmental disability" in RI general law, per § 8.1.4 herein.

D. These Rules and Regulations do not apply to the following:

1. Facilities, programs and services duly licensed by the Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) pursuant to 212-RICR-10-00-1 and 212-RICR-10-10-1 that are not required to have multiple licenses subject to § 8.1.1 (E) herein.

2. In-patient hospital children's services pursuant to 216-RICR-40-10-4.

3. Clinical services delivered in schools directly by school department personnel under contract or by other payment agreement with the school department as part of a student's Individualized Education Plan (IEP) or 504 Plan or for any other reason specifically related to the educational environment.

4. Child Placing Agencies, Child Caring Agencies, and Foster and Adoptive Homes licensed by the Rhode Island Department of Children, Youth and Families pursuant to R.I. Gen. Laws § 42-72.1.

5. Child Care programs licensed through the Rhode Island Department of Human Services (RIDHS) pursuant to R.I. Gen. Laws Chapter 42-12.5 and R.I. Gen. Laws § 42-12-23.

6. Health Care Facilities licensed by the Rhode Island Department of Health (RIDOH) pursuant to R.I. Gen. Laws Chapter 23-17.

7. Organized ambulatory care facilities, as described in R.I. Gen. Laws Chapter 23-17, that are owned and operated by professional service corporations, as defined in R.I. Gen. Laws Chapter 7-5.1.

8. A private practitioner's office (physician, dentist, or other licensed health care providers) licensed by the R.I. Department of Health (RIDOH).

9. A private practitioner delivering behavioral healthcare individually and solely under an individual license issued by RIDOH and not delivering services through employment with an organization subject to the regulations herein.

10. A group of practitioners (consisting of providers licensed by RIDOH whether owned and/or operated by an individual practitioner, alone or as a member of a partnership, professional service corporation, organization, or association), as described in R.I. Gen. Laws §§ 5-37-1(9) and 23-17-2(16).

E. Organizations, facilities, programs, or entities may be licensed by multiple state agencies at the same time when appropriate according to relevant R.I. General Laws.

F. An Organization must demonstrate both in its license application and through service provision the ability to provide behavioral healthcare services in accordance with these regulations and in compliance with the laws of the State of Rhode Island and federal law. The Department, as the Children's Behavioral Healthcare Organization (CBHO) licensing authority, will inspect all aspects of a program to determine compliance with these regulations. No organization will operate a CBHO without a license, per § 8.2.18 herein.

G. The terms and provisions of these regulations shall be liberally construed to permit the Department to effectuate the purposes of state law, goals, and policies.

H. Severability: If any provision in this chapter or the application thereof is held to be or made invalid by a court decision, statute, or rule or shall be otherwise rendered invalid, the remainder of the chapter and the application of that provision to other persons or circumstances shall not be affected.

7.1.2 Purpose

A. In accordance with R.I. Gen. Laws § 42-72-5, the Department is responsible for establishing appropriate behavioral health services that match the needs of children and families.

B. The purpose of licensing CBHOs is to safeguard the well-being of the children served and ensure the quality of services provided. It is the expectation of the Department that each child's array of supports and services be customized to meet the child's needs and desires in the least restrictive environment possible.

C. These regulations contain the licensing requirements for CBHOs that provide community and home-based behavioral health and/or intellectual developmental disability (IDD) services for children.

D. CBHOs must offer competent children's services, programs, and interventions that reflect professional best practices for children and their families that are based on a comprehensive understanding of child development; family systems/family-focused plans of care; trauma; child and adolescent diagnoses; child-specific behavioral management strategies; and risk factors for suicidality and self-harm, as well as abuse, neglect, mistreatment, and child sexual exploitation. These regulations also require that the provider be knowledgeable in the full range of children's services and resources, including but not limited to:

1. Available community supports and neighborhood resources.

2. Community behavioral health children's services, such as outpatient mental health, intensive outpatient, substance use treatment, and in-home services and supports.

3. Children's hospitalization and partial hospitalization programs and day programs.

E. The Department does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or disability. The prohibition against discriminatory practices extends to the agencies, organizations, and institutions the Department licenses.

7.1.3 Relevant Federal Law and Incorporated Materials

A. Providers are required to abide by all relevant state and federal law, including but not limited to the following federal statutes: 42 U.S.C. §§ 201(m), 290dd, 290ii, 300x,and 5101 *et seq*.; 42 U.S.C. § 5116 *et seq*., 42 U.S.C. §§ 10805, 10807, 10841, and 15043.

B. These regulations hereby adopt and incorporate Electronic Records/Electronic Signatures 21 C.F.R. § 11.1 et seq. (2021) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

C. These regulations hereby adopt and incorporate Protection of Privacy 21 C.F.R. § 21.1 (1985) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

D. These regulations hereby adopt and incorporate Confidentiality of Substance Use Disorder Patient Records 42 C.F.R. § 2 (2017) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

E. These regulations hereby adopt and incorporate Access to Records 42 C.F.R. § 51.41(b) (2025) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

F. These regulations hereby adopt and incorporate Definitions 42 C.F.R. § 431.201 (2016) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

G. These regulations hereby adopt and incorporate Agreement with State mental health authority or mental institutions 42 C.F.R. § 431.620 (1979) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

H. These regulations hereby adopt and incorporate Condition of participation: Client rights 42 C.F.R. § 485.910 (2013) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

I. These regulations hereby adopt and incorporate Security and Privacy, General rule and exceptions 45 C.F.R. § 102 et seq. (2013), 45 C.F.R. § 160.203 (2002), and 45 C.F.R. § 164 (2000), by reference, not including any further editions or amendments

thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

J. These regulations hereby adopt and incorporate Access to records 45 C.F.R. § 1326.25 (2016) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

K. These regulations hereby adopt and incorporate Access to children's service providers and children with developmental disabilities 45 C.F.R. § 1326.27 (2016) and 45 C.F.R. § 1326.30 (2016) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

L. These regulations hereby adopt and incorporate the federal Certification Criteria for Certified Community Behavioral Health Clinics, Substance Abuse Mental Health Services Administration (SAMHSA) 42 U.S.C. § 1305 referencing FR Doc. 2026-02187 Filed 2-2-26, CMS-10398 (#45) OMB Control # 0938-1148.

7.1.4 Definitions

A. "Advanced practice registered nurse" or "APRN" means:

1. The title given to an individual licensed to practice advanced practice registered nursing, as defined in R.I. Gen. Laws § 5-34-3 (2), within one (1) of the following roles: certified nurse practitioner (CNP) as defined in R.I. Gen. Laws § 5-34-3 (5), certified registered nurse anesthetist (CRNA) as defined in R.I. Gen. Laws Chapter 5-34.2, and certified clinical nurse specialist (CNS) and who functions in a population focus. An APRN may serve as a primary- or acute-care provider of record.

2. For the purposes of APRN practice pursuant to R.I. Gen. Laws § 40.1-5-5. § 40.1-5-7, § 40.1-5-8, §40.1-5-9, § 40.1-5-10, and § 40.1-5-11 and for APRNs who are certified and licensed in psychiatric/mental health, an advanced practice registered nurse (APRN) is the title given to an individual licensed to practice advanced practice registered nursing within one of the following roles: certified nurse practitioner (CNP) as defined under § 5-34-3 or certified clinical nurse specialist as defined under § 5-34-3 who functions in the population focus of psychiatric/mental health as defined under § 5-34-3(12)(vi) and whose scope of practice is defined under §§ 5-34-3(1), 5-34-3(2), and 5-34-3(15).

B. "Advanced practice registered nursing" means:

1. Generally, as defined in R.I. Gen. Laws § 5-34-3, an independent and expanded scope of nursing in a role and population focus approved by the board of nurse registration and nursing education that includes the registered nurse scope of practice and may include, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing, and ordering. Each APRN is accountable to patients, the nursing profession, and the board of nursing for complying with the requirements of R.I. Gen. Laws Chapter 5-34 and the quality of advanced nursing care rendered; recognizing limits of knowledge and experience; planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other healthcare providers as appropriate.

2. When practicing in the population focus of psychiatric/mental health including, but not limited to, practicing pursuant to R.I. Gen. Laws § 40.1-5-5. § 40.1-5-7, § 40.1-5-8, §40.1-5-9, § 40.1-5-10 and § 40.1-5-11, an APRN shall be certified and licensed in the population of psychiatric / mental health as defined under § 5-34-3(12)(vi) and whose scope of practice is defined under §§ 5-34-3(1), 5-34-3(2), and 5-34-3(15).

3. Notwithstanding the absence of certification and licensure in the population focus of psychiatric/mental health as defined under § 5-34-3(12)(vi), an APRN may be eligible for approval by BHDDH to act as a Qualified Mental Health Professional (QMHP). It is the responsibility of the APRN applicant for certification as a QMHP to obtain confirmation from the Rhode Island Department of Health (RIDOH) that the roles and responsibilities of a QMHP pursuant to the Mental Health Law, R.I. Gen. Laws §§ 40.1-5, are within the scope of practice of the applicant's APRN license.

C. "Advocate" means a:

1. Legal guardian or

2. An individual acting in support of or on behalf of the child in a manner consistent with the wishes of that child.

D. "Applicant" means a children's behavioral health care provider applying for a license or a license renewal to operate a Children's Behavioral Health Organization for children in the State of Rhode Island.

E. "Assessment" means the process of gathering biopsychosocial information, testing if warranted and performed by a qualified professional, and making a diagnostic judgment to determine a child's behavioral health status and need for services, conducted by a qualified staff person.

F. "Attribution" means, for the purposes of Certified Community Behavioral Health Clinics (CCBHCs), the process of assigning a child to a specific CCBHC and one of

the population rate categories established by the State. Attribution is used as the basis for Prospective Payment System (PPS) rate eligibility, program quality measurement, and data collection.

G. “Aversive techniques” means techniques requiring the deliberate application of discomforting, painful, or noxious stimuli (that would be so to the average person) to achieve a treatment or behavioral management objective.

H. “Behavioral healthcare” means the umbrella term that encompasses all assessment, treatment, prevention, and support services to address behavioral and mental health issues, serious emotional disturbance and intellectual developmental disability.

I. “Behavioral Healthcare Organization” or “BHO” means a public or private establishment licensed by BHDDH that is primarily constituted, staffed, and equipped to deliver mental health services to adults and/or substance use services to the general public, pursuant to 212 RICR 10-00-1 and 212 RICR 10-10-01. BHOs providing substance use disorder treatment to children or the general public are licensed through BHDDH and are not considered CBHOs under these regulations.

J. “Behavior management” means any intervention in which mutually acceptable behavioral goals and interventions are specified that utilize positive reinforcement and/or restrictions to help a child receiving services to develop and improve outcomes and address targeted behaviors. Behavior management is documented in a plan of care that is developed by agreement with the child served and a parent/legal guardian, as appropriate.

K. “Best practice standards” means principles of care that reflect the type and implementation of treatment and services recommended by research, professional literature, and professional experience.

L. “BHDDH” means the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals. BHDDH is the state agency responsible for licensing programs and services for substance use treatment and adult behavioral health and developmental disability services.

M. "Biopsychosocial Assessment" or “Comprehensive Assessment” or “Comprehensive Evaluation” means the process of gathering and documenting information through a comprehensive assessment of the functioning of the child and family to determine a child’s behavioral health status and need for services, approved by a licensed clinician. The assessment includes identification of the child’s strengths; preferences; cultural background and influences; previous or current involvement in behavioral health, child welfare, and/or social services; social history; and current functioning. The assessment also identifies current barriers and supports to the child’s functioning; family history and functioning; developmental history and cognitive functioning; child’s risk to self and others; community

involvement of the child; identification of medical history and medical conditions; and the child's educational needs.

N. "Board" means the Board of Directors of the Organization and/or the Advisory Board of a local Organization that is:

1. A for profit entity or

2. A nonprofit entity providing services in Rhode Island.

O. "Care" or "Treatment" means a set of individually planned interventions or supports that help the child work toward behavioral health or developmental goals and obtain or maintain an optimal level of functioning; reduce the effects of disability or discomfort; or ameliorate symptoms, undesirable changes, or conditions specific to physical, mental, behavioral, developmental, or social functioning.

P. "Care Coordination" means activities undertaken that have the purpose of planning, coordinating, and managing the care and services furnished to a child.

Q. "Care Planning Team" means a collaborative team that is meaningful to the child and family that includes the child, as appropriate, and legal guardian and that may include family members, family support partners, other natural supports, family liaisons, advocates, providers, and the family's service network to the greatest extent possible and appropriate. The Team comes together to build a comprehensive and effective plan that responds to the particular needs of the child and family.

R. "Case management" means a range of services provided to assist and support the child and family in developing their skills and gaining access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human needs; linkages and training for individuals in the use of basic community resources; and monitoring of overall service delivery.

S. "Catchment area" means "service area" as defined in R.I. Gen. Laws § 40.1-8.5-2(10) and in this Part. For purposes of this regulation, Catchment area only applies to CCBHCs.

T. "Certified Community Behavioral Health Clinic" or "CCBHC" means an organization that has been licensed by BHDDH as a Behavioral Healthcare Organization (BHO), as defined in 212 RICR 10-10-01; licensed by DCYF as a Children's Behavioral Healthcare Organization (CBHO); and certified by the Executive Office of Health and Human Services (EOHHS) to provide CCBHC behavioral health services in a manner that meets or exceeds CCBHC criteria pursuant to § 7.5.2 of this Part.

U. "CCBHC Interagency Team" means the interagency State team that works together to design, implement, and enhance Rhode Island's CCBHC program. The CCBHC

Interagency Team is comprised of staff from DCYF, BHDDH, and EOHHS. The CCBHC Interagency Team maintains shared advisory and decision-making powers related to State oversight of the CCBHCs. Responsibilities include, but are not limited to, developing and updating the RI CCBHC program certification requirements, compliance and quality oversight, and program evaluation.

V. "Change in operator" means a transfer of the authority of the Board of Directors, by the Board of an Organization, to any other person or group of persons (excluding delegations of authority to the medical or administrative staff of the Organization).

W. "Change in owner" means:

1. When an Organization is a partnership: the removal, addition, or substitution of a partner that results in the new partner acquiring a controlling interest in the Organization.

2. When an Organization is an unincorporated sole proprietorship: the transfer of the title and property to another person.

3. When an Organization is a corporation:

   a. A sale, lease, exchange, or other disposition of all or substantially all of the property and assets of the corporation.

   b. A merger of the corporation into another corporation.

   c. The consolidation of two (2) or more corporations resulting in the creation of a new corporation.

4. When an Organization is a for-profit corporation: any transfer of corporate stock that results in a new person acquiring a controlling interest in such corporation.

5. When an Organization is a non-profit corporation: any change in membership that results in a person acquiring a controlling vote in such corporation.

X. "Child" means any person younger than eighteen (18) years of age. Persons over the age of eighteen (18) shall be considered a "child" under the following conditions:

1. A person who received services prior to reaching majority and who continues to receive services after age 18; and/or

2. A person who is defined as emotionally disturbed and/or as a child with intellectual disabilities as referenced in R.I. Gen. Laws § 42-72-5; or

3. Any person who is subject to the continuing jurisdiction of the RI Family Court pursuant to R.I. Gen. Laws § 14-1-6.

Y. "Child abuse and neglect" means the maltreatment of a child as identified by R.I. Gen. Laws §§40-11-2 and 40-14-1.

Z. "Child-family competency" indicates proficiency in clinical practice skills with children experiencing behavioral health conditions, including serious emotional disturbance (SED), as well as intellectual developmental disability (IDD), and their families; thorough knowledge of child development; application of such knowledge in a clinical context; and familiarity and experience with community resources that benefit children and families, including knowledge of the cultural beliefs and practices of the diverse communities served.

AA. "Children's Behavioral Healthcare Organization" or "CBHO" or "Organization" means a public or private entity licensed by the Department and constituted, staffed, and equipped to deliver services to children of the general public for behavioral health, including serious emotional disturbances, and/or intellectual developmental disabilities, subject to the exceptions outlined herein at § 8.1.1(D).

BB. "Clinical staff" means any person employed or contracted by the Organization on a permanent or temporary basis to provide specialized clinical or therapeutic services to children in accordance with their individual qualifications and within the scope of the individual staff person's license.

CC. "Clinical screening" means the process of gathering demographic and clinical information when a child is potentially in need of or requests services from a CBHO. The screening is conducted to determine the child's level of care and risk, the type of service needed, and the child's eligibility and appropriateness for a particular service.

DD. "Complaint" means a formal, written request for further review of an unresolved concern or an allegation against a licensed Organization or provider regarding an alleged violation of ethical standards, regulations, or law. The source of the information may be anyone, including a child, client, parent, guardian, authorized representative, relative, representative of a client, employee, neighbor, an organization using the site, or others in the community.

EE. "Complaint Investigation" means the Department's review of information and records and Department-conducted interviews, including with service recipients and employees, to determine validity of an allegation against a CBHO of non-compliance with this rule.

FF. "Concern" is a matter that is perceived as interfering with a child's ability to maintain a level of functioning within major life domains and/or interferes with the child receiving adequate treatment.

GG. “Corporal Punishment” includes, but is not limited to, hitting, spanking, shaking, slapping, twisting, pulling, squeezing, or biting a child; demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures from a child; compelling a child to eat or have in the mouth soap, food, spices, or foreign substances; exposing a child to extremes of temperature; isolating a child in an adjacent room, hallway, closet, darkened area, or any other area where a child cannot be seen or supervised; and binding, tying, or taping to restrict movement.

HH. “Corrective Action Plan (CAP)” means a written document developed by the Organization and approved by the Department that specifies a step-by-step plan of action to address each out-of-compliance finding, violation, or deficiency. The CAP is developed to achieve targeted outcomes for resolution of identified deficiencies to:

1. Identify the most cost-effective actions that can be implemented to correct deficiency causes, including the processes that led to the deficiency cited;

2. Develop and implement a Corrective Action Plan to improve processes or methods so that outcomes are more effective and efficient;

3. Monitor the procedures that ensure that the Corrective Action Plan is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements;

4. Achieve measurable improvement in the highest priority areas; and

5. Eliminate repeated deficient practices.

II. “Cultural Competency” means core competencies within the practice of behavioral health services that include the understanding that perception of behavioral health conditions, crises, and their causes vary by culture; that culture influences help-seeking behaviors and attitudes toward behavioral health services; and that culture impacts emotional well-being. Culture also refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations and within society. Culture includes language; race; color; ancestry; nationality; ethnicity; ceremonial rituals and customs; gender identity or expression; sexual orientation; family structures; life-cycle stages; socio-economic status; abilities, and disabilities; as well as spiritual, religious, moral, and legal systems. Cultures are open dynamic systems that undergo continuous change over time.

JJ. “Curtailment” means the right of the Department to suspend or modify some or all activities of any Organization, if the Department has sufficient evidence to establish that the licensee has violated federal or state regulations.

KK. “Deficiency” means any failure of a CBHO to comply with any requirement within regulation, administrative rule, minimum standards, statute, or specific term of a license. A deficiency may present as an immediate or substantial threat to the physical health, mental health or safety of children receiving services from a CBHO.

LL. “Department” means the Rhode Island Department of Children, Youth and Families, also referred to as DCYF.

MM. “Designated Collaborating Organization” or "DCO" means an entity with whom a CCBHC has a formal relationship, evidenced in writing by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or other formal, legal agreement describing the parties’ mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. DCOs are not under the direct supervision of the CCBHC but are engaged in a formal relationship with the CCBHC to deliver one or more (or elements) of the required services as set forth herein at § 8.5.2 (G).

NN. "Designated service area” means the geographic area to be served by a CCBHC. Each service area, also referred to as a “catchment area” or “region,” is the same geographical area within the boundaries of cities and towns, designated by BHDDH for community mental health centers, as defined in Community Mental Health Services, R.I. Gen. Laws § 40.1-8.5-2 (10). CCBHCs are certified according to designated service area/catchment area/region.

OO. “Director” means the Director of the Department of Children, Youth and Families and their agents, designees or assignees.

PP. “Division of Community Services and Behavioral Health” or “CSBH” is the division within the Department that is responsible for the development and oversight of behavioral health and IDD supports, services, and/or treatment for children and families.

QQ. “Division of Licensing” means the division within the Department that is responsible for licensing provider Organizations.

RR. “Evidence-based practices (EBPs)” means interventions or services for which there is strong research demonstrating effectiveness in assisting children and families to achieve desired outcomes and which are implemented with fidelity to the researched model.

SS. “Evidence-informed practices” means the process and provision of care that incorporate evidence to guide clinical decision-making. This requires integrative consideration of best available research-based evidence; child and family presentation, needs, preferences, and values; the clinician’s experience and judgment; and the efficacy and context of the interventions.

TT. “Executive Office of Health and Human Services" or "EOHHS” means the principal agency of the executive branch of state governing (R.I. Gen. Laws § 42-7.2-2 responsible for managing the Departments Health (RIDOH); Human Services (DHS); Office of Healthy Aging (OHA); Office of Veterans Services (VETS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). EOHHS is also designated as the single state agency to administer the Medicaid program in Rhode Island. EOHHS is designated as the single state agency to administer the Medicaid program in Rhode Island.

UU. “Facility” means the CBHO’s designated physical site where programs and services are provided and/or overseen. A facility does not include family homes; locations in a child and family’s community that are not operated by the Organization and where community activities occur; or other informal sites.

VV. “Family-Centered Practice” means a best practice approach that allows the family’s strengths, resources, and needs to be identified between the family and Organization for the purposes of developing care plans and delivering services to children and families. Family-centered practice consists of the inclusion of the family member’s voice and choice as foundational to the decision-making process and is built upon principles that embrace valuing the family and utilizing the family’s community as a core support.

WW. “Full-time equivalent” or “FTE” means a unit of measurement that indicates the number of total hours worked divided by the maximum number of compensable hours in a full-time schedule as designated by an Organization or relevant law.

XX. “General Outpatient Services” means any clinical treatment that does not require overnight stay in a hospital or residential setting and is less intensive services than Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), high acuity or other intensive services, as defined herein.

YY. “Grievance” is a formal written request for further review of a complaint, concern, or an allegation against a licensed Organization or provider regarding an alleged violation of ethical standards, regulations, or law.

ZZ. “Health Information Exchange” means the technical system operated, or to be operated, by the Regional Health Information Organization (RHIO) under State authority allowing for the statewide electronic mobilization of confidential health information, regulated by R.I. Gen. Laws Chapter 5-37.7, and 216-RICR-10-10-6, Regional Health Information Organization and Health Information Exchange.

AAA. “Health Information Technology for Economic and Clinical Health Act” or “HITECH Act of 2009” means Pub. L. 111–5 FEB. 17, 2009, amended as the part of the American Recovery and Reinvestment Act of 2009, that incentivized the meaningful use of Electronic Health Records and strengthened the privacy and security provisions of HIPAA. Among other measures, the HITECH Act extended the reach

of HIPAA to business associates of covered entities who are now accountable for failures of HIPAA compliance.

BBB. "Health Insurance Portability and Accountability Act of 1996" or "HIPAA" means the federal legislation that establishes safeguards for patient privacy and health information. HIPAA sets strict standards for managing, transmitting, and storing protected health information. HIPAA applies to healthcare providers, insurers, and other organizations handling patient data and mandates safeguards to prevent unauthorized access or misuse of sensitive information 42 C.F.R. 403.812 (2003).

CCC. "Human Rights Officer" or "HRO" means a professional who is responsible for promoting, defending, or protecting human rights within the CBHO. The primary duties of a Human Rights Officer include monitoring human rights violations per law and the CBHO's internal policies; investigating allegations, complaints, and grievances; providing support and assistance to victims; and conducting human rights education to staff and stakeholders. HROs within CBHO must meet state requirements for training and education.

DDD. "Imminent risk of harm" means actions, omissions, or conditions that endanger life or seriously jeopardize physical or mental health or safety of self or others if protective action is not taken immediately.

EEE. "Incident" means a situation or event in which a child who receives services from an Organization licensed by the Department is harmed or is involved in an event that poses a potential risk of harm or injury to said person or concern for the child's health, safety, and/or welfare.

FFF. "Independent contractor" means a person who is not an employee of the Organization that provides or contributes to the direct service to a child and family.

GGG. "Informed Consent" means the permission given by the person who has the legal capacity to give consent or to authorize treatment. Such person:

1. Is able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other form of constraint or coercion and

2. Has been given sufficient information about the alternatives to and risks and benefits of the proposed treatment or procedure and the elements involved to be able to make a knowledgeable and enlightened decision.

HHH. "Intake" means the process that begins upon scheduling an initial appointment and involves initial screening, acceptance into a program or service, opening a treatment record, orienting the child and legal guardian to the Organization, assigning the child to an appropriate staff person or team, assessing and initial planning, as well as the completion of necessary document collection. It includes essential information

gathering and sharing between the Organization and the children and families that it serves. Information attained through intake shall guide the plan of care development. Children shall be admitted to the Organization no later than the third consecutive face-to-face clinical interaction

III. "Intensive Home-Based Services" or "IHBS" means evidence-based or evidence-informed mental health services administered through a team-based approach that provide individualized, time-limited, focused services directly to children and their caregivers in home and community settings on a frequent and consistent basis, aimed at improving behavior and preventing out-of-home placements or psychiatric hospitalization. IHBS are designed to meet each child and family's unique needs through crisis management, intensive case management, counseling, family therapy, and skill building.

JJJ. "Intensive Outpatient Program" or "IOP" means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in a child's home or in an inpatient or residential setting and that furnishes the services as described in § 8.5.5 herein. IOP services generally involve a minimum of nine (9) hours of services each week for a child, unless fewer hours are clinically documented as necessary, and not less than six (6) hours per week.

KKK. "Intellectual Developmental Disability" (IDD), also referred to as "Functional Developmental Disability" under R.I. Gen. Laws § 40.1-21-4.3, is defined as a disability characterized by severe, chronic limitations that is likely to continue indefinitely in both intellectual functioning and in adaptive behavior as shown in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency and that reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. Intellectual Developmental Disability generally presents with significant sub-average, general intellectual functioning two (2) standard deviations below the norm existing concurrently with deficits in adaptive behavior and manifested during the developmental period. Typically, the disability is based on severity (mild, moderate, severe, profound) through assessment of the child's IQ and the degree of support needed. The disability must have an onset before eighteen (18) years of age.

LLL. "Investigation" means a systematic review and search for facts. It is objective in nature and is intended to identify facts, sequence and chronology of events, active failure(s), latent failure(s), and assessment of risk as pertinent to a specific adverse event. An investigation may be undertaken in response to a complaint, an adverse event or incident report, or other information that comes to the attention of the Department or the Organization that requires additional review of the Organization's licensure status.

MMM. “Level of Care” or “LOC” means a particular amount of care and services required to meet a child's needs. Each level of care distinction has specific criteria associated with the programs and services that can be provided. Qualification for a specific LOC is determined by a qualified and licensed mental health professional who considers, among other items, the child’s risk of harm to self or others; the child’s functional status; and treatment history.

NNN. “Licensed Independent Clinician or Practitioner” means any individual who is permitted by law to provide behavioral health services without direction or supervision, within the scope of the individual’s license as defined by RIDOH.

OOO. “Licensed Practitioner of the Healing Arts” means a doctor and/or masters’ level clinician independently licensed in the State of Rhode Island as defined by state Medicaid program requirements in medicine, psychology, nursing, social work, mental health counseling or marriage and family treatment who is required to sign the child’s plan of care, among other duties.

PPP. “Limited English Proficiency” means an individual does not speak English as his or her preferred language and who has a limited ability to read, write, speak, or understand English in a manner that permits him or her to communicate effectively with providers and have meaningful access to and participate in the services, activities, programs, or other benefits administered by providers, in accordance with applicable state and federal law.

QQQ. “Linguistic Competency” means the capacity of an Organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are non-readers of English, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served.

RRR. “Medication Management” or “Psychiatric or psychotropic medication management” refers to the process and practice of evaluating a patient's diagnostic and clinical needs; identifying if and which medication or medications might be indicated to target symptoms; prescribing and providing medication(s); and providing ongoing education and monitoring to ensure safe, effective, and optimal use of medications as part of a comprehensive treatment plan.

SSS. “Mental health professional” means, as defined by the Mental Health Law in R.I. Gen. Laws § 40.15-2, a psychiatrist, psychologist, or social worker and such other persons, including a psychiatric nurse clinician and licensed advanced practice registered nurse (APRN).

TTT. “Mental Health Law” means the Rhode Island Mental Health Law, codified in R.I. Gen. Laws Chapter §§ 40.1-5.

UUU. “Nationally recognized model of crisis intervention and physical restraint” means a crisis intervention and restraint program that is developed by an Organization with the capacity to ensure quality training in, and evaluation of, the model consistent with § 7.4.9 of this part.

VVV. “Nurse Practitioner” means a type of APRN.

WWW. “Orientation” means a process to provide initial information about the CBHO and its services to children and families served and to staff of the Organization. For staff, orientation includes an assessment of their competence relative to their job responsibilities and the Organization’s mission, vision, and values.

XXX. “Parent” means the parent(s) or legal guardian(s) of a child.

YYY. “Partial Hospitalization Program” or “PHP” means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or inpatient or residential setting. PHP furnishes the services described in § 8.4.6 herein.

ZZZ. “Plan of Care,” also known as a treatment or service plan, means the written plan that results from a collaborative process between the child served and the service provider that specifies the services and supports that are furnished to meet the preferences, choices, abilities, and needs of the child; describes the activities and services that will guide the child’s efforts toward improvement; and incorporates information collected during the assessment. The plan of care identifies the intended resolution to the mental health crisis or condition that is developed by the clinician or treatment team in partnership with the child, when appropriate, and parent or legal guardian and family of the child. The plan considers the strengths of the family and child and all available community services and matches the services to the needs of the child and family. A plan of care may include a behavioral support plan and/or an intervention plan as components.

AAAA. “Plan of Care Review,” also known as a treatment plan review, means a team-based planning and review process intended to provide individualized, coordinated, family-driven care to meet the complex needs of families and children. Identified services are flexibly adjusted as the child and family’s needs change.

BBBB. “Program” or “Service” means individually planned support and structured intervention delivery that provides specific components of treatment that is responsive to the child’s and/or family’s emotional, behavioral, or mental health or developmental needs.

CCCC. “Protected Health Information” or “PHI” means individually identifiable health information, as defined in 45 C.F.R. § 160.103.

DDDD. “Provider” means an organization that manages or delivers clinical and/or support services to children and families; see also “CBHO.”

EEEE. “Qualified mental health professional” or “QMHP” means a mental health professional, as defined in this Part and R.I. Gen Laws § 40.1-5-2, and as approved by BHDDH.

FFFF. “Registered Nurse” or "R.N." means an individual who practices “professional nursing" pursuant to R.I. Gen. Laws §§ 5-34-3(11) and (14). The practice of professional nursing is a dynamic process of assessing an individual's health status, identification of healthcare needs, determination of health care goals with the child’s and/or family’s participation, and the development of a plan of nursing care to achieve these goals. Nursing actions, including teaching and counseling, are directed toward the promotion, maintenance, and restoration of health and evaluation of the individual's response to nursing actions and the medical regimen of care. The professional nurse provides care and support of individuals and families during periods of wellness and injury and incorporates, when appropriate, the medical plan of care as prescribed by a duly licensed physician, dentist, or podiatrist or other licensed healthcare provider authorized by law to prescribe. Each R.N. is directly accountable and responsible to the consumer for the nursing care rendered.

GGGG. “Restraint” means any direct contact intervention, hold, or behavior management technique that is used to control acute, episodic behavior or that is intended to prevent, restrict, or subdue the movement of the whole or portion of a child’s body as a means of controlling a child’s physical activity to protect the child or others from injury. See §§ 8.4.8 and 8.4.9 herein.

1. “Chemical Restraint” or “Pharmacological Restraint” means medication that is given for the emergency control of behavior when the medication is not standard treatment for the child’s medical or psychiatric condition.

2. “Mechanical Restraint” means the use of a mechanical device to control acute, episodic behavior and prevent, restrict, or subdue the freedom of movement or voluntary functioning of a limb or a portion of a child’s body as a means to control his or her physical activities.

3. “Physical Restraint” means the use of approved physical interventions or “hands-on” hold to prevent a child from moving his or her body to engage in a behavior that places the child or others at risk of physical harm.

HHHH. “RIDOH” means the Rhode Island Department of Health as defined under R.I. Gen. Laws § 23-1.

IIII. “Seclusion” means involuntary confinement or retention, for any period of time, of a child to any room, area or space from which the child may not freely exit or from which the child believes he or she may not exit.

JJJJ. “Serious Emotional Disturbance” or “SED” means an emotional, behavioral or mental disorder for which a child under the age of 18 has received a diagnosis through the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) or current International Classification of Disease (ICD). Such conditions must have been ongoing for one year or more or have the potential of being ongoing for one year or more. SED, as defined within the state of Rhode Island, may persist through 21 years of age. Of note, the following disorders do not qualify as SED unless they occur in conjunction with another diagnosable SED: substance usage disorder; mental disorder due to a medical condition such as traumatic brain injury; or intellectual developmental disorder.

KKKK. “Staff” means and includes, but is not limited to, any employee, intern, trainee, independent contractor or volunteer performing a service or activity for the Organization, including any designated collaborative organization (DCO), to meet the needs of children served for which competent performance is expected.

LLLL. “Telemedicine Coverage Act” means R.I. Gen. Laws § 27-81, which establishes regulations for telemedicine services in Rhode Island.

MMMM. “Variance” is an administrative decision that allows an Organization to meet a standard for licensure in a manner other than that specified in the regulations. A variance is granted for a time-limited period on a case-by-case basis only when the purpose of the licensing standard is achieved, and the safety of children served is maintained.

NNNN. “Violation of human rights” means any action or inaction which deprives an individual of any of his or her civil rights, as articulated in federal or state law or in this Part.

OOOO. “Waiver” means an administrative decision that allows case-by-case exemptions from compliance with a non-safety related standard. A waiver is granted for a time-limited period on a case-by-case basis only when the purpose of the licensing standard is achieved, and the safety of the children served is maintained.

7.2 APPLICATION FOR LICENSURE, RENEWAL, OR CHANGE IN LICENSURE STATUS

7.2.1 Application for Licensure, Renewal, or Change in Licensure Status

A. No Organization, acting separately or jointly with any other person or entity, establishes, conducts, or maintains a children’s behavioral healthcare organization, facility, site, or program that provides community or home-based mental and behavioral healthcare or intellectual developmental disability services to children without a license, pursuant to R.I. Gen. Laws Chapter 42-72.1, unless otherwise duly licensed under any other R.I. General Law.

B. Any Organization, acting separately or jointly with any other person or entity, interested in opening, establishing, or conducting a children's behavioral healthcare organization, facility, site, or program to provide community or home-based behavioral healthcare or intellectual developmental services to children, pursuant to R.I. Gen. Laws 42-72.1, must contact the Department of Children, Youth and Families' Division of Licensing to apply for a Children's Behavioral Healthcare Organization (CBHO) license.

1. All Organizations who propose to provide services, supports, and treatment for the behavioral health, and/or IDD needs of children must submit a licensing application for each site that includes all supporting documentation.

2. A licensed CBHO that also has been certified as a Medicaid provider by EOHHS shall maintain both a CBHO license and Medicaid certification. Any CBHO that is also a CCBHC must maintain both CBHO licensure and CCBHC certification.

C. Any CBHO with a valid adult BHO license must submit a copy of the license(s) to the Department.

D. Approval of a license to provide community or home-based behavioral healthcare or IDD services to children requires compliance with these regulations. The Department grants applicable licenses to Organizations providing services and to the Organization site at which the services are delivered. Services may be delivered in the home or community in accordance with the needs of the child.

E. To obtain and maintain a full license, the CBHO must demonstrate full compliance with these regulations at all times.

F. Granting a license means there is clear evidence that the CBHO can provide effective evidence-based or evidence-informed services, supports, and treatment for children.

7.2.2 Application for Initial Licensure or Renewal

A. An application for a CBHO license is required as follows:

1. To conduct, maintain, or operate a CBHO.

2. To renew a license for a CBHO.

3. When there is a change in owner or operator.

4. When there is a new legal affiliation of two (2) or more organizations.

B. All BHDDH licensed Behavioral Healthcare Organizations (BHOs) and Developmental Disability Organizations (DDOs) that provide behavioral health or IDD services to adults in Rhode Island must meet all the requirements contained in these regulations and be licensed as CBHOs, if also providing such services to children, excluding programs solely addressing substance use for children.

C. To ensure smooth transition; provide adequate time for affected Organizations to meet licensure requirements; and prevent administrative backlog, the initial implementation of the requirements contained within this Part will follow a staggered schedule. Beginning upon promulgation:

1. Existing BHOs applying for initial CBHO licensure shall have a license duration that aligns with the existing BHO license to facilitate simultaneous renewal.

2. Organizations applying for CBHO licensure without a BHO license shall have six (6) months from promulgation to apply for a CBHO license.

D. Upon approval by the Department, including the onsite review, an applicant for licensure is granted a CBHO license that remains in effect for up to two (2) years. To remain a licensed provider, the provider must maintain compliance with all requirements contained within these regulations.

7.2.3 Components of Licensing

A. The licensing application process includes, but is not limited to, a review of the Department's application completed and submitted by the prospective Organization.

B. The licensing application process also includes, but is not limited to, a review of the prospective Organization's:

1. Mission and vision statements that guide the Organization's administrative operations and delivery of services.

2. Corporate philosophy and ethics.

3. Organizational background and corporate history.

4. Experience providing services to individuals, including children and families, in Rhode Island and other states.

5. Corporate type (including tax-exempt status, if applicable) and experience.

6. Financial disclosure information, audits, fiscal capacity verification, tax compliance, and written policies and procedures related to financial solvency.

7. Evidence of liability and malpractice insurance sufficient to cover the scope of any programs or services the Organization provides.

8. Demonstrated commitment to children and families.

9. Provisions for how children and families who are served participate in the operation of the Organization.

10. Strategies for promoting culturally competent and culturally sensitive community access and engagement.

11. Strategies for providing voice and choice in choosing providers and services for all children and families.

12. Human rights officer.

13. Board of directors.

14. Staffing plan.

15. Staff experience/qualifications.

16. Job descriptions.

17. Staff resumes.

18. Staff recruitment, selection, training, and supervision approaches.

19. List of all staff, contractors, and volunteer background checks upon hire per R.I. Gen. Law § 40-13.2-5(c).

    a. State DCYF checks, as detailed in Child Abuse and Neglect Registry Check, 214-RICR-10-00-1.7.

    b. State and nationwide criminal background checks, as detailed in Criminal Record Background Checks, 214 RICR 10-00-1.8.6.

    c. Fingerprinting / national criminal history results.

    d. Criminal History Affidavit (DCYF # 109).

    e. Employment History Affidavit (DCYF # 108).

20. Behavior management, physical intervention, and/or restraint policies and evidence of training on a nationally accredited model, per § 8.4.9 herein, if applicable.

21. Conflicts of interest.

22. Plan or procedure for periodic systems/program evaluation and review.

23. Accreditation certification (e.g., COA, CARF, JCAHO, etc.), as applicable:

a. The following documentation is required from the Organization for consideration of accreditation:

(1) A copy of the certificate awarded by the accrediting body. If an Organization has received certification from a national accreditation body, the Department may substitute relevant accreditation review findings for related licensure requirements.

(2) The accrediting body's written report regarding its survey results.

(3) The Organization's response, if any, to the report of results from the accrediting body.

(4) The services included in the accreditation shall include those subject to CBHO licensure.

b. The Department may deem the Organization in compliance with relevant licensure standards, in part or whole, after considering the extent of compliance with the accrediting body's standards.

C. The Organization shall demonstrate compliance with applicable laws and regulations.

D. The Organization shall submit to readiness reviews and onsite visits to ensure preparedness for programming and service provision.

E. If an applicant fails to provide complete, accurate, and truthful information during the application and licensing process, licensure may be delayed, or the Department may deny or revoke the license.

F. Any applicant or person with a controlling interest in a CBHO will be considered responsible for acts occurring during, and relating to, the operation of licensed services or the Organization for the purpose of licensing.

G. The Department may consider the background and operating history of the applicant(s) and each person with a controlling ownership interest when determining to issue a license.

H. When an application for licensure is made by an applicant(s) who owns or operates other licensed Organizations in Rhode Island, the Department may deny the license if the applicant's existing Organizations are not, or have not been, in substantial compliance with the applicable Rhode Island licensing authority regulations and/or health and safety standards.

7.2.4 Application and Approval Process

A. An application for licensure or renewal shall be submitted to the Licensing Division of the Department using forms provided by the Department. The application contains such information as the Department requires, including, but not limited to, evidence of the ability to comply with all applicable Department rules and regulations. A separate application must be filed for each proposed Organization.

B. The completed licensing application packet, in accordance with § 8.2.3 herein, must be submitted to the Department's Licensing division to initiate the licensing process. An incomplete packet will be returned to the applicant if not completed within thirty (30) days of notification of incomplete status.

C. A preliminary site evaluation is performed by the Department's Licensing and CSBH staff, after all application materials have been received and reviewed for qualifying compliance. A site visit includes physical inspection of the site(s); review of policies and records; a potential quality or preparedness review of programs and services; and any other task necessary to effectively ascertain the site's readiness for licensure.

D. Upon reviewing the appropriately completed application and reviewing the applicable site(s) for compliance, the Department will either approve or deny an initial or renewal application and, if approved, issue or renew a full license.

E. Notice and response time to an application for licensure determination is sixty (60) days from receipt of completed application.

F. Such license is issued to the applicant or licensee to operate specific programs and sites or facilities. It is not transferable or assignable except with the Director's or designee's written approval.

G. A license continues in effect after the end of the licensure period if the Organization has submitted a timely and sufficient renewal application and there are no grounds to deny the license under any provision of this Part.

H. The Organization shall notify the Licensing Division and CSBH in writing of any plans to suspend services or end services or to close a program at least ninety (90) days prior to any proposed suspension, cessation, or closure.

I. The license shall be returned to the Department immediately upon surrender, suspension, or revocation of the license.

J. The procedure for applying for approval for alterations or additions to a current site shall be made by completing an application change form provided by the Department and by attaching plans and specifications prior to commencement of construction pursuant to R.I. Gen. Laws § 42-72-5.

7.2.5 Mergers, Affiliations, Change of Ownership

A. The Department, and if required, any federal, state or accrediting authority, shall be notified of any proposed mergers, affiliations or change of ownership, program sponsor, or operator at least ninety (90) days prior to that proposed merger, affiliation, or change. Any such change or action will require the application for and issuance of a new license.

B. In cases where the application involves a merger, consolidation, or other legal affiliation of two (2) or more Organizations, the application shall include the proposed immediate and long-term plans of such Organizations with respect to the programs to be offered and services to be provided by such Organizations because of the merger, consolidation, or other legal affiliation.

7.2.6 Provision of Licensure

A. The CBHO is responsible for adhering to the requirements of the CBHO license, which indicates the following:

1. The physical location(s) of the Organization in Rhode Island.

2. Dates of validity.

3. Programming options approved for the Organization.

B. The current license must be posted in a conspicuous place.

C. If there are any inaccuracies on the printed license, the Organization is responsible for contacting the Department to rectify the error.

D. The license is granted only to the designated Organization and is limited to the stated location and listed approved services and program types.

E. The CBHO applicant may be subject to multiple licenses if:

1. The CBHO applicant operates in multiple parts of a building that is also used for another purpose.

2. The CBHO applicant runs multiple programs in one building that are maintained separately for security or another purpose.

3. Certain programming facilitated through the CBHO's license may necessitate additional licenses, as applicable, within the Department and/or by other state department regulations.

7.2.7 License Modification

A. Upon written request by the CBHO, the Department may modify the current license with respect to the populations served, programs and services offered, or locations where programs and services are provided. The CBHO must obtain a license change request form from the Department and submit it to the Department's Division of Licensing.

B. Approval of such a request is at the sole discretion of the Department. Any change that requires license modification must not be implemented before approval by the Department is granted and the modified license is issued.

C. When the operation of a CBHO is discontinued voluntarily or a change of ownership is planned, the licensee provides the Department's Licensing and CSBH Units with written notification at least ninety (90) days before closure.

D. When there is a change in ownership or in the operation or control of an Organization, the Department reserves the right to extend the expiration date of such certificate, allowing the Organization to operate under the same license which applied to the prior license holder for such time as is required for the processing of a new application or reassignment of participants, not to exceed six (6) weeks.

7.2.8 License Renewal

A. At least sixty (60) days before an existing Child Behavioral Healthcare Organization license expires, a CBHO must submit a renewal application with all supporting documentation. Providers can obtain the renewal application from the Department's Division of Licensing.

B. While CBHO licenses are valid for up to two (2) years, CBHOs may desire to renew the CBHO license at the same time as any adult BHO/DDO licenses. Renewal applications can be considered prior to expiration to effectuate a simultaneous licensing process.

C. The CBHO must continue to demonstrate compliance with these regulations throughout the renewal process.

7.2.9 Licensing Actions

A. The Department may take licensing action against the license in whole or in part.

B. The Department determines, in part or whole, which of the services, programs, and/or sites or premises included by the Organization on the application for licensure or renewal will be granted licensed status.

C. Determination**:**

1. Upon successful completion of the licensing process, the Department takes one of the following actions within sixty (60) days:

    a. Issue a license.

    b. Deny the application and inform the applicant of the right to appeal pursuant to Appeals Process and Procedures for EOHHS Agencies and Programs, 210-RICR-10-05-2.

2. If an Organization fails to provide complete, accurate, and/or truthful information during the application and licensing process, the Department is empowered to delay a licensure decision or may deny or revoke the license.

3. Per § 7.2.10 of this Chapter, if at any time, the Organization violates the terms of the license or application:

    a. A plan of corrective action may be required.

    b. The Department may pursue administrative, civil, and/or criminal remedies according to applicable Rhode Island General Laws; and/or

    c. A license may be denied, suspended, or revoked.

4. A license may be denied, suspended, or revoked for:

    a. Failing to comply with these or other applicable regulations.

    b. Providing falsified or misleading statements and/or documentation to the Department; and/or

    c. Making efforts to deceive the Department.

5. If the Department takes licensing action to suspend or revoke the license, the Organization shall be obligated to:

    a. Post the Department's notification of this action in a prominent location near the site entrance.

b. Notify the legal guardians of any child receiving services about the reasoning and timing of the licensing action.

c. Provide the Department with information about any children and families impacted by a licensing action, upon request.

6. The CBHO license remains valid until licensing renewal, or as otherwise consistent with R.I. Gen. Laws § 42-72.1-5, unless the Department initiates a licensing action for cause or the licensee voluntarily surrenders the license prior to that time.

7.2.10 Licensing Action Determinations

A. The Department may deny, suspend, withdraw, amend, refuse to issue or renew, or revoke the license of, or the operation of a specific program authorized under the license of, if the Department has sufficient evidence to establish that the licensee has violated federal or state statute or regulation upon notice to the Organization and the opportunity for administrative hearing or upon settlement by consent agreement or order.

B. Procedure for review relating to licensing actions: The Department may take reasonable steps to ensure potential licensing violations, complaints, or grievances are addressed. If there is reasonable cause to believe a licensing violation, complaint, or grievance exists or that there is imminent danger to the physical and/or emotional well-being of the child receiving services and supports, the Department adheres to the following procedure:

1. The Department's Licensing Administrator or designee sends a written Notice of Potential Licensing Action to the chief executive of the CBHO that details the potential violation(s), complaint(s), grievance(s), and/or circumstances creating the risk of imminent danger.

2. The Department informs the Organization that the Department is considering a licensing action, provide notice of the facts that may warrant this action, and establish a deadline for response.

3. The notice expresses willingness to meet with the CBHO and provide a date and time for the meeting.

4. At the meeting, the CBHO shall be given the opportunity to show cause why the action shall not be taken.

5. If, after the meeting, the facts continue to warrant a licensing action, written notification of that licensing action is sent to the CBHO within ten (10) days. The notice establishes a deadline for correction.

6. The chief executive of the CBHO shall send a Corrective Action Plan to the Licensing Administrator, CSBH Administrator, or designees within the time frame specified by the Department. The Department will work with the CBHO to ensure the Corrective Action Plan adequately addresses the alleged violation(s), complaint(s), grievance(s), and/or imminent danger(s).

7. If the CBHO fails to comply with the terms of the Corrective Action Plan within the timeframe of the Corrective Action Plan, the chief executive officer shall send a written explanation for the delay and a specific request for extension to the Licensing Administrator, CSBH Administrator, or designees with a request for an amended timeframe. This request must be received at least twenty-four (24) hours before the deadline.

8. The Licensing Administrator or designee accepts or rejects the request in writing. If the CBHO remains in violation at the end of the designated time frame, the Licensing Administrator or designee initiates action to suspend or revoke the license.

9. The CBHO is notified in writing of its right to appeal the decision through an administrative hearing, per § 7.2.12 of this Chapter.

10. To the extent this procedure may conflict with the provisions of R.I. Gen. Laws § 42-35-14(c), the statute shall prevail.

C. Pursuant to R.I. Gen. Laws § 42-72.1-7, in response to any routine or emergency monitoring, review, and/or identified deficiencies, the Department may impose the following Licensing actions:

1. Require the CBHO to correct the deficiency through cure, training, or other reasonable remediation.

2. Limit programming, services, or staffing that the CBHO can provide.

3. Issue fines per R.I. Gen. Laws § 42-72.1-7.

4. Change the status of a license.

5. Suspend a license.

6. Revoke a license.

D. Denial: A license may be denied if the Department finds the Organization has done any of the following:

1. Failed to comply with CBHO regulations.

2. Failed to comply with applicable state or local laws, ordinances, rules, and regulations, including but not limited to those pertaining to health, safety, fire prevention and protection, building, sanitation, and zoning.

3. Violated of any of the provisions under which the license was issued.

4. Made any fraudulent or misleading statements in order to maintain or retain the license.

5. Employed any person who, within five years of the date of application for a license, has been convicted of a felony against persons, injury or risk of injury to a minor, or for the sale of a controlled substance.

E. Suspension in Emergencies: If the Director finds that public health, safety, or welfare requires emergency action and the Department incorporates such findings into a written directive, the Director may order the summary suspension of the license or curtailment of activities, as detailed above, pending proceedings for revocation or other action in accordance with R.I. Gen. Laws § 42-35-14(c).

F. Revocation: The Department may revoke the license or refuse to renew the license for any of the following reasons:

1. Failure to comply with CBHO licensing rules.

2. Failure to comply with applicable state or local laws, ordinances, rules, and regulations, including but not limited to those pertaining to health, safety, fire prevention and protection, building, sanitation, and zoning.

3. Violation of any of the provisions under which the license was issued.

4. Failure of the CBHO to submit required licensing documentation.

5. When continued operation of any CBHO presents an imminent danger to the health, safety, or welfare of any child.

6. Failure of the CBHO to submit the specified written response to a site review report by the required date.

7. Failure of the CBHO to correct any identified area of non-compliance within the timeframe provided by the Department in the notice of non-compliance.

G. Licensing Actions specific to CCBHCs

1. Any licensing action taken by the Department with respect to a CCBHC license will not necessarily adversely impact on an underlying CBHO license.

The status of an underlying CBHO is evaluated independently from its CCBHC license.

2. Any CCBHC that intends to surrender its license to operate as a CCBHC shall notify the Department, in writing, six (6) months prior to ceasing operations. Within forty-five (45) days of providing written notice, the CCBHC shall provide to DCYF, BHDDH, and EOHHS a written transition plan which details how it intends to transition children who receive services from the CCBHC to other providers or to other service delivery models. The Department shall have the authority to review and approve the transition plan and shall notify the CCBHC of its decision.

H. The Department may, in lieu of revocation or refusal to renew a license, elect other administrative sanctions, including, but not be limited to, prohibiting the CBHO from continuing to admit clients, or requiring the removal, relocation, or referral of clients to other licensed provider(s) through a Corrective Action Plan as outlined in § 8.2.15 herein.

I. The Department may accept the voluntary surrender of part or whole of a license for an Organization when the licensed service(s) are no longer going to be provided. The Organization shall provide a written transitional plan that details how the Organization intends to transition children already receiving the licensed service(s) from the Organization to other providers for up to ninety (90) days or until alternative service arrangements can be made for the affected children.

J. Notwithstanding any other legal or statutory reporting requirements, any complaint that alleges that a child has been abused and/or neglected by CBHO staff, employees, interns, directors, or volunteers must be referred to the appropriate police department.

K. The Department coordinates with other state licensing agencies regarding licensing actions, including Corrective Action Plans, as required by department procedures, administrative rules, other state regulations, and / or local, state, or federal law.

7.2.11 Variance or Waiver

A. An Organization may apply for a variance or waiver at any time.

B. The request for variance or waiver shall be sent to the Department's Licensing Division in writing with an explanation of the Organization's intent to meet the spirit of the regulation being varied or waived and/or its intent over time to meet the stated regulation as written.

C. No variance or waiver to a regulation may be considered granted until the Organization has received written approval from the Department.

D. No provision or procedure prescribed by state or federal statute will be waived.

E. The Director or designee may grant a variance or a waiver for a specific timeframe when the situation does not jeopardize the health, safety, or well-being of the children served.

F. To request a variance or waiver, a CBHO must submit the following to Licensing:

1. A statement of the type of hardship that would result to the program if a variance or waiver were not granted.

2. Clear clinical or programmatic justification for such variance or waiver.

3. Documentation to support the request of the variance or waiver.

7.2.12 Right of Appeal

A. A licensee has the right to appeal any decision made by the Department.

B. All appeals, hearings and reviews required pursuant to these Rules and Regulations shall be held in accordance with the provisions of R.I. Gen. Laws Chapter 42-35 and the Executive Office of Health and Human Services (EOHHS) Rules and Regulations for Appeal Process and Procedures for EOHHS Agencies and Programs (210-RICR-10-05-2).

7.2.13 Monitoring and Review

A. The Department will make any inspections and investigations deemed necessary, according to Department rules and regulations.

1. Authorized persons from the Department must be able to access the grounds, buildings, and all books and records relating to the Organization.

2. The Department is entitled to receive information and assistance from all persons connected with the Organization for any examination or inquiry as the Department may require.

3. The Department investigates complaints and potential violations of licensing regulations. The Organization shall cooperate fully with any investigation.

B. Any non-compliance with the regulations cited herein constitute valid grounds for licensure action.

7.2.14 Reports of Deficiencies

Reports of deficiencies noted in inspections conducted in accordance with these and other applicable regulations, results of any Departmental investigation, and plans of correction or compliance orders as described herein are maintained on file at the Department and shall be considered by the Department in rendering determinations to deny, suspend, or revoke the license or to curtail certain specific activities and programs of an Organization.

7.2.15 Corrective Action Plans

A. Findings of noncompliance may require corrective action as specified by the Department, in accordance with state and federal rules, regulations, and statutory requirements. Failure to meet remediation requirements may result in penalties up to and including license suspension or revocation by the Department and/or fines and/or certification action by EOHHS in accordance with DCYF and EOHHS rules, regulations, and statutory requirements. Any Corrective Action Plan as required by the Department shall comply with the procedures delineated in § 8.2.12 herein.

B. Per §§ 8.2.9 and 8.2.10 herein, the Department notifies the Executive Director or other Organization legal authority of violations of any part of this Chapter through a Notice of Deficiency, unless the Department determines that immediate action is necessary to protect the health, safety, or welfare of the public (or any member thereof) through the issuance of an immediate, written Notice of Non-compliance.

1. An immediate Notice of Non-compliance identifies violations of the applicable licensing standards and instruct the Organization to immediately comply with such order.

2. A copy of the Notice of Non-compliance is maintained in the Organization's provider file within the Licensing Division.

C. The Organization that receives a Notice of Deficiency must submit a Corrective Action Plan, which shall include timeframes for completion, to the Department within thirty (30) days of the date the Organization receives the Notice of Deficiency. The Corrective Action Plan may include any requests for variances in accordance with the variance procedures requirements per § 8.2.11 herein. The plan shall include evidence of compliance for each resolution or a plan for how evidence will be presented upon resolution.

1. Upon request from the Department, the Organization shall submit a Corrective Action Plan not more than thirty (30) days after notice of deficiency.

2. An amended Corrective Action Plan shall be submitted if the Department determines that the initial submission is insufficient to address the deficiencies. The amended Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the Organization's receipt of the request for an amended Corrective Action Plan.

D. If the Department rejects the Corrective Action Plan, the Organization does not provide a Corrective Action Plan within the stipulated period, or the Organization whose Corrective Action Plan has been approved by the Department fails to execute its plan within a reasonable time period, as determined by the Department, the Department may invoke the sanctions enumerated at 8.2.10(C) herein.

E. If the Organization is aggrieved by the action of the Department, the Organization may appeal the decision and request a hearing in accordance with R.I. Gen. Laws Chapter 42-35.

7.2.16 Grievances/Complaints

A. Reports of grievances noted in the Department's routine or emergency inspections or made through external report, results of any Departmental investigation, and plans of correction or compliance orders, as described herein, are maintained on file at the Department and are considered by the Department in rendering determinations to deny, suspend, or revoke the license or to curtail certain specific activities and programs of an Organization.

B. CBHOs must report to the Department any internal findings of deficiency upon occurrence.

C. Grievance procedure

1. Every CBHO must establish an accessible grievance procedure.

2. The grievance procedure must be presented to every person served in a clear, easily understood manner consistent with the child's learning style and conspicuously posted in the CBHO. The notice of grievance procedure includes the name and contact information of organizations that provide free legal assistance.

3. The child or legal guardian served is entitled to initiate a grievance. The CBHO must encourage and assist the child and their legal guardian, as required by law, in exercising their rights.

4. The child or legal guardian served initiates the grievance by filing a grievance with the director of the CBHO or designee. The director forwards a copy of the grievance form to the CBHO's Human Rights Officer (HRO).

5. The director of the CBHO, or their designee, with the assistance of the HRO, or their designee, investigates the grievance and provides a written decision to the person within ten (10) days of receipt of the grievance. The written decision includes a copy of the grievance; a list of anyone interviewed in the

investigation; the steps taken to resolve the grievance; and the outcome, decision, or conclusion to the CBHO director or their designee.

6. The HRO, or their designee, if necessary, assists the person in requesting a review.

7. If the child receiving services or legal guardian is not satisfied with the outcome of the grievance proceedings, the person may file for an administrative hearing in accordance with the Appeals Process and Procedures for EOHHS Agencies and Programs (210-RICR-10-05-2).

E. Complaint Investigations

1. The Department will accept complaints from any person about alleged violations of this rule.

2. The CBHO must not retaliate against any child, legal guardian, or their representative for filing a complaint.

3. The Department has the right to conduct unannounced onsite reviews.

4. The Department may investigate or have investigated on its behalf:

a. Complaints;

b. Incidents of suspected abuse, neglect, or exploitation;

c. Allegations of rights violations;

d. Allegations of the CBHO's failure to comply with these regulations, laws, or relevant rules;

e. Allegations of aiding, abetting, or permitting a violation of these regulations, laws, or relevant rules; or

f. Allegations of conduct in the operation or maintenance of a CBHO that threatens or is deleterious to the physical health, mental health, welfare, or safety of any individual.

5. Any licensing violations noted as a result of a complaint investigation will be provided to the CBHO in writing.

7.2.17 Protection of Rights: Human Rights Officers

A. Each Organization must designate at least one person employed by or affiliated with the Organization to serve as a human rights officer (HRO). The HRO must, to the

extent possible, have no duties that may conflict with the responsibilities as an HRO. The Organization must ensure that the HRO is given the time and resources to perform the entailed human rights responsibilities.

B. The name of the HRO and the method for contacting the HRO are given to all children served and are posted in a conspicuous place, such as waiting rooms and other common or public places at all sites where the Organization provides services.

C. Individuals selected to fulfill the responsibilities of an HRO must have satisfactorily completed an HRO training program approved by the Department and, at a minimum, must possess the following qualifications:

1. Ability to serve as an advocate for all children or families served while working cooperatively and effectively with staff.

2. Knowledge and skills to conduct investigations.

3. Capacity to perform responsibilities impartially.

D. The responsibilities of the HRO include the following:

1. Ensuring that children and families served are informed of their rights and given opportunities to receive education regarding their rights.

2. Providing ways for children served to have an opportunity to discuss and ask questions about their rights.

3. Training all staff regarding the rights of children and families served, as defined in these regulations.

4. Assisting children and families served to exercise their rights.

5. Monitoring the implementation of human rights regulations throughout the Organization.

6. Fulfilling all HRO responsibilities specified in the Organization’s Grievance Procedure.

E. The above responsibilities are included in the HRO's position description, and their performance relative to these responsibilities is evaluated at least annually.

7.2.18 Operation of an Unlicensed Organization

The Department may impose fines or other sanctions for the operation of an unlicensed organization, site, program, or service in accordance with R.I. Gen. Laws § 42-72.1.

7.2.19 Provider Governance

A. Leadership and Organization Planning

1. The Organization shall operate in accordance with all applicable local, state and federal laws, rules, and regulations.

2. When a board of directors is required by the corporate structure of an organization, the Organization shall have an organized board that functions as its governing body and that is ultimately responsible for:

    a. Program and fiscal management and operation of the Organization.

    b. Assurance of the quality of services.

    c. Compliance with all federal, state, and local laws and regulations pertaining to Organizations, and the regulations herein.

    d. Compliance with all applicable components of the Americans with Disabilities Act and other federal and state disability civil rights laws.

3. The board shall provide appropriate organizational oversight.

4. The board shall include persons who represent the greater community, including individual and family participation. At least twenty-five percent (25%) of the board shall be persons who reflect the population served by the Organization and/or family members of individuals. At a minimum, one (1) Board member shall be an individual or family member of an individual served. Evidence of compliance shall be provided to the Department upon request but shall be non-public for purposes of R.I. Gen. Laws Chapter 38-2. Efforts shall be made to recruit members who represent the cultural diversity and population of the local community served by the Organization.

5. The board of directors shall adopt by-laws, or an acceptable equivalent, that shall:

    a. Describe the lines and levels of authority for relationships among itself, the executive director or equivalent position, and the community.

    b. Define the ethical standards and the responsibilities for the governance of the operation and performance of the Organization.

    c. Stipulate at least four (4) regular meetings of the board of directors each year and shall describe qualifications for membership and quorum requirements and require recording of minutes.

6. There shall be a written statement of the specific responsibilities of the board of directors.

7. The board of directors shall review and approve major program changes recommended by the executive director or equivalent position.

8. The board of directors shall adopt an annual budget, approve policies, receive written reports of income and expenditures by program, and receive a copy of the annual audit.

9. The board of directors shall be responsible for annually evaluating the performance of the executive director or a person serving in an equivalent position of the Organization.

10. A written plan shall define the mission, vision, and values for the Organization as well as strategic, operational, program-related, and other plans and policies to achieve them.

11. The Organization shall have a written policy and procedure manual that shall be implemented, reviewed, and updated as necessary.

12. The leadership of an Organization shall develop programs to promote staff recruitment, retention, development, and continuing education.

B. Financial management

1. The Organization shall develop an annual operating budget and long-term capital expenditure plan and strategy to monitor the implementation of the plan. The plan shall include the following:

    a. An authorized budget with a review of financial performance at least quarterly.

    b. Provisions for meeting the needs of children and families served and producing the desired outcomes.

    c. Attention to long-term financial solvency.

    d. Processes to ensure that Organization systems are in place to ensure Organization-appropriate funding streams are available to carry out the purpose for which the Organization is licensed.

    e. Identification of the sources of funding for the operations of the Organization.

2. The Organization shall contract with an independent certified public accountant to conduct an annual audit of the Organization's financial statements.

3. The Organization shall provide audited financial statements, audit findings and any recommendations, including corrective action plans, and any supplemental schedules, as may be required by the Department, upon request.

4. The Organization shall secure insurance to:

    a. Cover damage, injury, or loss of life caused by fire, accident, or any other dangers that might occur during the operation of the Organization.

    b. Provide liability coverage for all vehicles owned, leased, or operated by the Organization.

    c. Carry worker's compensation insurance in accordance with the laws of the State of Rhode Island.

    d. Protect the personal funds of individuals, to cover damage, injury or loss of life caused by fire, accident or any other dangers which might arise in the operation of the Organization.

5. The Organization shall maintain its financial records in accordance with generally accepted accounting and bookkeeping practices.

6. The Organization shall have the infrastructure and ability to develop, support, and maintain a billing system that can track services provided and bill accordingly.

7. The Organization shall bill the appropriate entity for services rendered to individuals in accordance with the appropriate program requirements.

8. Economic Distress and Going Concern Issues: In the event that an Organization anticipates that its financial viability is becoming structurally unsustainable, its projected net billing or revenue is projected to be negative for longer than usual, or its expenses are projected to exceed regular billing or revenue for longer than usual, the Organization shall immediately notify, in writing or by electronic mail, the Licensing Administrator, CSBH Administrator, or designees. The written communication shall include the reason or reasons that the Organization believes it is in economic distress beyond expected, episodic, and routine indebtedness and/or negative cash flow. In the event that the Organization's accountant prepares a Going

Concern statement, the Organization shall notify the Department immediately.

C. Organization Ethics

1. Each Organization shall have a written Code of Ethical Conduct.

2. The Organization's written Code of Ethical Conduct shall address ethical issues in the management and provision of services and in the implementation of clinical practices pursuant to these regulations.

3. All staff, volunteers, and independent contractors directly involved in services shall adhere to both the code of ethics of their respective disciplines, as applicable, and the Organization's Code of Ethical Conduct that shall include:

   a. Use of accurate and respectful language in all communications to and about children and families served.

   b. Prohibition from engaging in or promising to engage in a personal, scientific, professional, financial, or other relationship that is outside the professional relationship sanctioned by the Organization with children and families currently or formerly served by the Organization.

   c. Prohibition on taking advantage of any professional relationship or exploit others for their personal, religious, financial, sexual, political, or business interests.

   d. Respect for the confidentiality of each child and family served.

4. The Organization's policies and procedures shall reflect ethical practices for marketing, admission, transfer, and billing.

5. The Organization's Code of Ethical Conduct shall address the provision of appropriate care without consideration of the individual's personal financial resources.

6. The Organization’s Code of Ethical Conduct shall include a policy regarding gifts, goods, or services given to or received from children or families served.

7. The Code of Ethical Conduct shall be made available in a written or electronic form at all licensed sites where services are provided and shall be communicated to all personnel and to all children and families served during orientation to the Organization and shall be available upon verbal or written request.

8. Training regarding the Code of Ethical Conduct shall be provided to all staff, volunteers, consultants, and contractors, as applicable. A record of this training shall be maintained by the Organization.

9. The Organization shall have a written policy and procedure to address any violation of the Code of Ethical Conduct.

10. All staff, volunteers, and contractors affiliated with the Organization who are serving children and families shall sign a copy of the Code of Ethical Conduct to indicate that they understand the responsibility to abide by these standards; the signed copies shall be maintained in the individual's personnel file.

11. The Organization shall not take retaliatory or punitive action against any employee, child. or family served for their report of a possible or perceived violation of any rule, regulation, standard, or statute committed by the Organization or by an employee of the Organization.

7.2.20 Quality Performance/Improvement and Individual Satisfaction

A. All Organizations shall have written policies and procedures for assessing individual satisfaction with services and supports received, individual choice regarding services received, and individual involvement in monitoring and directing the provision of services.

B. The Organization shall have an effective, ongoing, organization-wide quality performance/improvement program to evaluate the provision of services and supports to children and families served that addresses the quality requirements of the CBHO regulations.

7.2.21 Duty to Report

A. CBHOs are subject to duty to report and are mandated to report when known or suspected cases of child abuse or neglect occur. CBHOs must provide notification to the RI Department of Children, Youth and Families' Child Protective Services hotline (1-800-RI-CHILD/1-800-742-4453) within 24 hours of becoming aware of such abuse or neglect, as defined in R.I. Gen. Laws §§ 40-11-2, 40-14-1 and 40.1-5-40.1, in accordance with state law and Department policy.

B. Additionally, any Organization shall be responsible to make a telephone report to the Department's Licensing Division within twenty-four (24) hours after an observation of an overt act; after an observation of physical harm to a child; after receipt of an oral, written, or gestured disclosure, any of which make a reasonable person believe that the child was subjected to a violation of his or her civil rights, including, but not limited to, financial exploitation; mistreatment; neglect; and/or verbal, mental, sexual, or physical abuse; injury of unknown source; death that may

have been caused by abuse or neglect; and/or misappropriation of client property by anyone.

C. Any person within the scope of their employment at an Organization or in their professional capacity who has knowledge of or reasonable cause to believe that a child in a program has been abused, mistreated or neglected by staff, board, employees, Independent Contractors, or volunteers shall file within twenty-four (24) hours or by the end of the next day, a written report to the Department. A police report or report to other state agencies may also be required by law.

D. For every report required by §§ 7.2.21 (A), (B), or (C) of this Part, the information in such telephone or written report shall include at least the following:

1. The caregiver or employee's name, Organization address, Organization telephone number, direct extension if applicable, and occupation.

2. The name and address of the child who is believed to be the victim of the abuse, mistreatment, or neglect.

3. The details, observations, and beliefs concerning the incident(s).

4. The child's oral, written or gestured statements regarding the incident(s), to whom they were made, and at what date and time they were made.

5. The date, time, and place of each incident.

6. The name of all individuals believed to have knowledge of the incident(s).

7. The name of all individuals believed to have been responsible for the incident(s) or those who could have been responsible for the incident if unknown cause and unknown perpetrator.

E. Such written report that is provided by the deadline in this section shall be made available to the Licensing and CSBH divisions upon request, or within five (5) days of the incident(s), whichever occurs earlier.

F. Any deadline to file a written and/or telephone report of an alleged violation of civil rights, or of an alleged act of abuse, neglect, mistreatment or exploitation against a child, shall not be extended even if a reporter is allowed to inform a "high managerial officer" of the reporter's Organization.

G. The Organization shall immediately inform the legal guardians and/or others of any situation involving abuse, neglect, mistreatment, or human rights violations against the child. In case of an accident, injury, or death of a child, the managing officer shall complete a written report to the Licensing division within twenty-four (24) hours of the child's accident, injury or death. The writer of the report shall include the

circumstances of the injury or death as fully as possible, including but not limited to the information listed in § 7.2.21 (A) of this Part. Any such record shall be accessible only to the Director of the Department or any such employee designated by the Director as having a need to know such information, unless an applicable law or regulation otherwise permits.

7.2.22 Internal Investigation Protocol

A. The Organization shall have a written policy specifying designated, authorized individuals who are responsible for conducting investigations in the event of a serious reportable incident and specifying the action or procedures the employee may take.

1. The Organization will establish capacity to implement investigatory protocol established by the department.

2. The Organization's policy shall specify the intent of an investigation to determine all the facts around a reported incident and to protect any individual from any further harm.

B. The Organization shall provide information and data on the numbers and types of incidents that are internally reported at the request of the Department.

C. Nothing herein shall change the timeframe for report to the Child Abuse Hotline and the Licensing Division pursuant to R.I. Gen. Laws §§ 40-11-2, 40-14-1 and 40.1-5-40.1.

D. Based upon the results of its investigation, the Organization shall provide the Department with written recommendations to prevent further abuse, mistreatment, or neglect of the child or other program individuals.

1. The investigative analysis will evaluate if any other risk to the child or other individuals remain.

2. The Organization shall complete a final investigative analysis report using current standardized forms or protocol provided by the Department and shall submit the report to the Department.

E. The Organization shall take all necessary steps to prevent and protect a child who has been a victim of abuse, neglect, mistreatment, or other violation of any basic human rights from further abuse.

F. When abuse is alleged or death of a child has occurred and a law enforcement agency, or the Department, or the Department's designee, has determined to initiate an investigation, the Organization shall not endeavor to investigate unless directed by the Department to do so.

G. The Organization shall provide information on the conclusion and recommendations of a completed investigation to the alleged victim or his or her legal guardian, as requested by the child and/or their legal guardian.

1. The Organization shall develop a safety plan as well as a risk assessment for the alleged victim because of any investigation in which the allegation has been substantiated or inconclusive.

2. The Organization shall develop a quality improvement plan within twenty (20) days to ensure the health and safety of the child.

3. The Organization shall complete a status report within three (3) months, responding to the recommendations that were made.

7.2.23 Event/Incident Reporting

A. Reportable events as defined herein in subsection (E) shall be reported to the Department via mechanism defined by the Department.

B. CBHOs shall report incidents as defined in subsection (E) to the Department within twenty-four (24) hours of when the incident occurred or within twenty-four (24) hours of receipt of information causing the CBHO to believe that a reportable event has occurred.

C. CBHO incident reporting policies and procedures shall, at minimum, address and include annual training for staff on the following topics relative to Reportable Incidents:

1. Identification.

2. Reporting requirements and documentation.

3. Triage.

4. Investigation.

5. Response and Resolution.

6. Tracking and Evaluation.

D. Reportable event policies shall include the following, at minimum:

1. All policies and processes relative to § 7.2.23 (C).

2. An incident report shall be submitted in written form to the CBHO's Executive Director or designee within twenty-four (24) hours of discovery of a reportable incident.

3. The Organization shall maintain an ongoing log of its reportable incidents for departmental review.

E. Reportable Events shall include, but are not limited to, the following:

1. Physical Injury that occurs during the course of treatment and results in medical care provided outside the CBHO's application or use of basic first aid.

2. Child abuse and neglect per RIGL §40-11.

3. Abuse, neglect, exploitation, or maltreatment of a child served by a CBHO by an employee, contractor, staff member, volunteer, or board member of the CBHO.

4. Any sexual contact involving a minor, non-coerced or otherwise, that occurs at a provider site or alleged to have been perpetrated by an employee, contractor, staff member, volunteer, or board member of the CBHO.

5. Any misconduct, including deliberate, willful, unlawful, or criminal activities that pose a serious threat to the health, safety, or well-being of children and families served by an employee, contractor, staff member, volunteer, or board member of the CBHO.

6. Gross deviation from quality expectations leading to serious harm of a child receiving services.

7. Medication error or pattern of medication errors caused by any Organization employee, staff, volunteer or other individual formally involved with a CBHO in the administration of a medication that adversely affects a child receiving services; the primary care physician shall also be notified.

8. Vehicle collision involving staff and child served.

9. All unauthorized use of restraints by Organization staff or when an authorized use of restraint by Organization staff results in injury requiring medical attention.

10. Any use of seclusion or other prohibited practice pursuant to § 7.4.10 of this part by CBHO staff.

11. Unscheduled implementation of any part of an Organization's fire/evacuation/disaster plan, including fire, flood, serious property damage or internal disasters at a site where behavioral health services are delivered or events that jeopardize the health, safety, or well-being of staff or children and families served or that significantly disrupt Organization operations, including disasters or other emergency situations external to the freestanding Organization's site environment that adversely affect site operations.

12. Law enforcement intervention whereby an Organization's staff was an alleged perpetrator.

13. Elopement of a child from the care or oversight of a CBHO staff person.

14. Any reportable infectious disease outbreak as defined in 216-RICR-30-05-1 at an Organization's facility.

14. Death of a child during or related to service delivery.

15. Strikes by personnel.

16. Unscheduled termination of any services vital to the continued safe operation of the facility or to the health and safety of any children, families or staff.

17. Confidentiality violation.

18. Ethics violation.

19. Human rights violation.

20. Staff to staff physical altercation.

21. Breach of data/information technology system.

F. CBHOs shall also report critical incidents/reportable events to all required local, state, and federal agencies, as required by law.

G. Nothing in this section shall prohibit the Department from investigating any event or incident.

H. When a critical incident occurs, any information relating to the critical incident or the participant shall be kept confidential, and only necessary information shall be released to essential personnel, such as police, medical personnel, crisis intervention, etc., to ensure the participant's health and welfare and/or complete the critical incident report.

7.2.24 Policies and Training

A. The Organization shall have written policies and procedures for assuring the health, safety, and well-being of the population participating in their programs that are consistent with these regulations. These policies shall:

1. Include definitions of abuse, neglect, mistreatment, other human rights violations, and serious incidents.

2. Explain the types of incidents that need to be reported within the Organization, in compliance with § 8.2.23 herein.

3. Explain the process for reporting and documenting the incident.

4. Delineate the responsibilities of employees for conducting and/or participating in investigations that involve a violation of a person's rights or a serious incident.

5. Include provisions for administrative action, disciplinary action, and dismissal of employees, contractors, and volunteers involved with abuse, neglect, mistreatment, or other human rights violations.

B. Staff Training

1. The Organization shall have established orientation and annual training programs for all new and existing employees as required in their job description. Staff training records shall contain dated documentation of completion, including verification.

a. Staff shall receive documented competency-based training at orientation or onboarding, and annually thereafter, to include the Organization's:

(1) Mission and Culture.

(2) Child and family-centered philosophy and approaches to child and family-centered planning in behavioral health.

(3) Strategic plan.

(4) Organization-specific policies and procedures.

(5) Quality assurance and performance improvement.

(6) Training requirements.

b. Minimum annual training for all employees

(1) Fire safety training, which includes training in the program's emergency evacuation procedures.

(2) Compliance and ethics.

(3) Children's rights, rights of individuals, human rights, and the role of the Organization's human rights officer.

(4) Detection and prevention of abuse, neglect, mistreatment, financial exploitation and other human rights violations.

(5) Procedures for mandatory reporting of allegations of abuse, neglect, mistreatment or other human rights violations to the Child Abuse Hotline and Licensing/CSBH divisions~~;~~ various state agencies; and/or other entities such as police and human rights committee.

(6) Confidentiality.

(7) Effective Communication.

(8) Social determinants of health (SDOH) and Adverse Childhood Experiences (ACEs).

(9) Trauma-informed behavioral healthcare (including trauma-specific treatment approaches).

(10) Child Development.

(11) Best practices in health equity and inclusivity for children of various racial, ethnic, religious and cultural backgrounds; children with disabilities; and children with marginalized identities.

(12) Best practices in delivering culturally responsive, inclusive behavioral healthcare.

c. Job-specific training, as applicable

(1) Grievance and appeal procedures.

(2) Service quality.

(3) Overview of child and family-centered planning in compliance with Medicaid Home and Community Based Services (HCBS) regulations (210-RICR-50-10-1).

(4) Behavioral supports, healthcare and medication administration training.

(5) Development and implementation of behavioral supports.

d. All staff working with children must be trained within ninety (90) days of employment in the most recent guidelines of the American Heart Association for the following:

(1) Pediatric cardiopulmonary resuscitation (CPR).

(2) Pediatric first aid.

(3) Renewal certification must occur within ninety (90) days of expiration for both Pediatric CPR and first aid.

e. All program staff providing or supervising direct services to children and families shall have the following child and family competencies:

(1) Knowledge of child development, behavior, and psychopathology: Staff members involved in direct services shall have a strong understanding of child development and behavior, including the normal range of emotions and behaviors for children at different ages. This includes knowledge of the normal developmental milestones for children, as well as the signs and symptoms of common mental health disorders in children.

(2) Skills in child-specific risk and safety identification: Staff working directly with children shall have the ability to identify a child's risk of suicide; non-suicidal self-injury; aggression; abuse, neglect and exploitation; exposure to violence and/or other types of traumas; human trafficking; fire setting; substance use; chronic AWOL; or other clinical presentations that pose an immediate risk or safety issue.

(3) Skills in crisis identification: The staff working with children and families shall have strong skills in crisis identification and support for children and families. This includes the ability to identify if a crisis situation exists and provide supports to the child and family during a crisis.

(4) Knowledge of community resources: The staff working directly with children and families shall have knowledge of community resources that can be helpful to children and families. This includes knowledge of behavioral health services, social services, and other community resources.

(5) Cultural competence: Staff working directly with children and families shall be culturally competent and aware of and sensitive to the cultural beliefs and practices of the children and families they serve.

2. Organizations that utilize an online learning management system shall have a protocol in place that requires employee registration. The evidence of training may include a completion certificate and/or access to the system for review by staff.

3. Organizations shall determine staff training needs and develop a schedule of ongoing training programs that will be offered to employees. The training opportunities will be individualized based on the needs of the children and families served by the Organization.

4. Licensed staff shall be required to maintain their licenses in good standing, including all requisite training per the scope of the individual license.

7.2.25 Personnel

A. The Organization shall implement personnel policies and procedures.

1. The Organization will maintain written personnel policies and procedures, which will be provided to staff at the time of orientation that:

a. Comply with all applicable state and federal statutes, rules, and regulations regarding non-discrimination in employment practices.

b. Include language for conducting reference, background, and employment checks as detailed in Child Abuse and Neglect Registry Check, 214-RICR-10-00-1.7 and Criminal Record Background Checks, 214 RICR 10-00-1.8.6.

c. Detail any fringe benefits provided to full-time and part-time employees and any reimbursement procedures (as applicable and appropriate).

d. Address suspension, increased supervision, or other appropriate disciplinary employment procedures.

e. Provide written job descriptions that include minimal qualifications for each position, major duties, responsibilities, reporting supervisors, and positions supervised.

f. Include a process for evaluating the job performance of each staff member at the end of the initial training period and annually thereafter.

g. Include a provision governing conflicts of interest.

2. Staff will work regularly scheduled hours, and the Organization will maintain a record of work assignments.

3. Clinical and administrative leaders shall define, for their areas of responsibility, the qualifications and competencies of staff needed to fulfill the Organization's mission. Staff qualifications shall be commensurate with job responsibilities and applicable licensure, law, regulation, registration, and/or certification.

4. The Organization shall provide professional development opportunities to all staff that maximize individual competencies.

5. The Organization shall have recruitment and retention policies to increase the number of personnel who reflect the cultural diversity of the communities in which the CBHO provides services.

6. The Organization shall have policies for recruiting leadership that is culturally representative of the children served by the Organization.

B. "Duty to Report" Personnel Policies and Procedures

1. The Organization shall have policies and procedures that prohibit retaliation against any staff who report suspected abuse, neglect, or mistreatment or retaliation against the involved child with respect to any report.

2. Personnel policies and procedures language must also include:

a. A requirement that all personnel participate and cooperate with all authorized persons conducting investigations or regulatory reviews involving the Organization and/or any person receiving supports or services from the Organization.

b. A process for annual notification of mandatory reporting statutes to all employees, advisors, skill trainers, respite providers, contractors, and volunteers of the Organization.

C. Staff Qualifications and Personnel Files

1. Any employee providing direct assistance to a child or legal guardian shall meet the following criteria:

    a. Be at least eighteen (18) years of age.

    b. Have clear job responsibilities as described in a current and dated job description.

    c. Have a high school diploma or a GED.

2. The Organization will have a personnel file for each employee and contractor, which contains the following:

    a. The application for employment, resume, and references.

    b. State and nationwide criminal background checks upon hire, as detailed in Criminal Background Records Check, 214 RICR 10-00-1.8.6.

    c. Fingerprinting / national criminal history results upon hire.

    d. State DCYF checks, as detailed in Child Abuse and Neglect Registry Check, 214-RICR-10-00-1.7 upon hire.

    e. Affidavit signed by each employee and contractor stating understanding that each person is responsible for notifying the Organization within 24 hours of any CPS involvement, arrest, charges, and/or sentences in any state. Upon notification, the Organization must immediately determine if such incident is grounds for suspension and/or termination based on the RI Code of Regulations.

    f. Criminal History Affidavit (DCYF # 109).

    g. Employment History Affidavit (DCYF # 108).

    h. Performance evaluations.

    i. Personnel actions relating to the individual's employment with the Organization.

    j. Evidence of any professional certifications, licenses, and renewals, as applicable.

    k. Reference and qualification checks.

l. Evidence of continuing education and required training hours as listed in § 8.2.24(B) herein. Documentation of completion of training in crisis de-escalation; restraints and seclusion (if utilized by the Organization); and certification in First Aid and CPR, with evidence of annual compliance.

m. Beginning and end dates of employment.

3. The annual employee evaluation process shall include the following:

a. An assessment of job performance in relation to the required skills and expectations set forth in the job description.

b. A documented review of the evaluation with the staff maintained within the personnel record.

c. Documentation that individuals served by the employee had input into this process, to the extent possible.

4. Organizations will maintain a file for each volunteer and intern containing the following upon the start date:

a. State and nationwide criminal background checks, as detailed in Criminal Background Records Check, 214 RICR 10-00-1.8.6.

b. Affidavit signed by each volunteer stating understanding that each person is responsible to notify the Organization within 24 hours of any CPS involvement, arrest, charges, and/or sentences in any state. Upon notification, the Organization must immediately determine if such incident is grounds for suspension and/or termination based on the RI Code of Regulations.

c. Fingerprinting / national criminal history results.

d. State DCYF checks, as detailed in Child Abuse and Neglect Registry Check, 214-RICR-10-00-1.7.

e. Criminal History Affidavit (DCYF # 109).

f. Employment History Affidavit (DCYF # 108).

g. A signed confidentiality agreement.

h. Volunteers and interns will comply with the same ethical requirements as staff.

5. Personnel records must be retained for six (6) years from date of termination.

7.2.26 General Staffing Requirements

A. All Organizations licensed by the Department to provide services and programs to children and families must have staff with appropriate training, education, experience, credentials, clearances, and licenses to deliver the services and programs covered in this Part.

B. All behavioral health staffing shall be appropriate to meet the needs of the following populations:

1. Children and adolescents with behavioral health disorders, including serious emotional disturbance (SED); and/or

2. Children with intellectual developmental disabilities.

C. Staff providing services, supports, treatment, and/or programs shall possess a comprehensive understanding of child and family-driven care; child development; childhood and adolescent diagnoses; interventions involving family systems; behavior management strategies; and trauma-informed care, including as it relates to child abuse, neglect, and sexual exploitation.

D. Staff Shortage: In the event that an Organization experiences a shortage of staff that is unplanned and that is not projected to be remedied through its usual hiring process within the usual amount of time needed to fill staff vacancies, the Organization shall immediately notify, in writing or by electronic mail, the Department Director or designee. The written communication shall include the number and type of vacancies and the reason or reasons that the Organization believes it is unable to fill its staff vacancies within the usual amount of time.

E. Family Engagement

1. The CBHO will incorporate family systems and family-centered practice and planning that will involve the parent/guardian and family in the plan of care in accordance with the child's plan of care.

2. The CBHO shall provide culturally and linguistically sensitive care and communication to both the child served and the legal guardian(s) of the child who is enrolled whose primary language is not English or who require alternative methods of communication. CBHOs must be able to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including children and families of limited English proficiency (LEP), those who have limited literacy skills, and children with disabilities (e.g., phone lines and web sites that assure access for people who

are deaf or hearing impaired; interpretation services; translated materials for children and their families who do not speak or read English).

3. Auxiliary aids and services shall be made available and be responsive to the needs of a child's legal guardian to provide access to meaningful participation in the child's services.

4. The Organization must ensure there is a means of competent, effective, and reliable communication between staff and the legal guardian that may include written, telephonic, electronic, and face-to-face communications.

5. The Organization shall engage families in the child's plan of care in a manner that exhibits cultural awareness and sensitivity.

6. The Organization shall have policies and procedures to address requests by children (or legal guardian) served for a change of provider, clinician, or service.

F. Staff Interaction with children: While working with children and their families, CBHO staff are required to:

1. Maintain consistent contact (e.g., face-to-face and collateral contact) with the child, family, natural and/or peer supports, and care planning team per Organization programming and plan of care guidelines.

2. Maintain a therapeutic relationship with the child by providing care that is responsive, attentive, consistent, comforting, supportive, linguistically appropriate, and culturally sensitive and create a positive environment through staff behaviors.

3. Maintain staff professionalism respective to the specific CBHO by serving as a positive role model and support for the child and family (e.g., encouraging appropriate behavior and setting clear limits).

4. Maintain the use of positive methods that are both evidence-based and evidence-informed in guiding and directing the child and family's plan of care, including behavior management strategies.

5. Assist children who present with challenging behaviors and their families, by, at a minimum:

   a. Identifying and documenting factors that may predict or contribute to the challenging behavior.

   b. Making adaptations to the child's treatment, plan of care, and service delivery, as necessary.

c. Supporting families by sharing verbal information and written materials.

d. Providing connections to relevant services and outside resources, when necessary.

e. Ensuring that services rendered through the plan of care match expectations with the child's developing abilities and capabilities, according to child and adolescent development; and including approaches to treatment that incorporate principles of family voice and choice; use of natural supports; collaboration; cultural competence; and team-based, individualized, strengths-based, and outcome-based approaches.

G. Supervision is required for staff providing direct services and supports (i.e., direct staff) designed to address a behavioral health condition or intellectual developmental disability as follows:

1. All staff providing direct services in licensed CBHOs who are not licensed independent practitioners must receive clinical supervision. Licensed clinicians shall follow best practices, ethical standards, and industry standards for providing supervision.

2. Hours of supervision are pro-rated for actual hours worked each month.

3. All professionally licensed staff who provide a clinical or medical service and are not independent practitioners receive supervision on a regular schedule that occurs at least monthly with preference for a minimum of four (4) hours of clinical supervision per month (pro-rated for part-time clinicians) that consists of at least half of the supervision completed as individual supervision. Each month the remaining hours of clinical supervision may be in a group setting.

4. Direct service staff who do not have a professional license receive supervision on a regular schedule that occurs at least monthly with preference for a minimum of four (4) hours of clinical supervision per month (pro-rated for part-time direct service staff), at least half of which is completed as individual clinical supervision. Each month the remaining hours of documented clinical supervision may be in a group setting.

5. In addition to all training items listed in § 8.2.24 herein, supervision shall include the following topics:

a. Ongoing and comprehensive training.

b. Understanding scope of practice.

c. Cultural and linguistic awareness.

d. Case conceptualization, including handling of complex cases.

e. Conflict resolution.

f. Staff competency, ongoing training, professional development, and self-evaluation.

g. Staff conduct, roles, and responsibilities.

h. Confidentiality and use of PHI.

i. Ethical, legal, and regulatory issues.

(1) Ethical decision-making.

(2) Boundaries.

(3) Self-disclosure.

(4) Attending to safety.

(5) Standards of care/best practices.

j. Documentation

(1) Timeliness.

(2) Policy, procedures, and contractual obligations.

(3) Supervisor sign-off responsibilities.

(4) Maintenance, security procedures, and information sharing.

6. All clinical supervision must relate to the service the staff person is providing to children and families and is documented.

H. Clinical Supervisors

1. Staff providing clinical supervision must have at a minimum, the qualifications, education, credentials, license, and experience relevant to the staff, programs, and services being supervised.

2. Supervisors' experience and knowledge must include, and is not limited to, diagnostic evaluation; family, group, and individual therapy (with emphasis on family systems and family-focused plans of care); medication services; emergency interventions; and child-family specific competencies, such as childhood trauma, child sexual exploitation, child substance use disorder, child mental and behavioral health, child and adolescent development, and childhood diagnoses; and maintain one of the following licenses:

    a. Licensed Independent Practitioner, which includes Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, Licensed Independent Clinical Social Worker, Medical Doctor, Licensed Ph.D., Licensed Psychologist, Licensed Nurse Practitioner, Advanced Practice Registered Nurse, and Licensed Applied Behavior Analyst (LBA), and two (2) years of full-time experience providing relevant behavioral health services.

    b. Registered nurse, with either an American Nurses Credentialing Center certification as a Psychiatric and Mental Health Nurse or at least two (2) years of full-time experience providing relevant behavioral health services.

3. Clinical supervisors for services for children with intellectual developmental disabilities shall additionally have core competencies with applied behavior analysis or similar behavioral interventions.

7.3 PHYSICAL SITE

7.3.1 Management of the Environment of Care

A. The Organization shall plan for and provide a safe, accessible, effective, and efficient environment consistent with its mission, services, and applicable federal, state and local laws, codes, rules, and regulations that comport with all aspects of this Chapter.

B. The Organization shall ensure that all the Organization's sites and locations where services are provided are accessible to meet the needs of people receiving services from the Organization and designed to protect the health and safety of all persons.

C. The Organization shall ensure the sites and locations where services are provided are in compliance with all local, state, and federal laws, including building codes and fire inspections.

D. The Organization shall also ensure that all sites and locations where services are provided are clean, sanitary, in good repair, free from accumulation of combustible debris and waste material, and free from offensive odors and insects and pests.

E. The Organization is responsible to report to Licensing any failure of mechanical systems at any site or other location that impacts programming.

F. Any proposed changes to any Organization's site must be made in accordance with state and local laws, with notice to the Department in accordance with this Chapter.

G. Restrooms shall be available and accessible for individuals and staff in all the Organization sites where licensed services are provided.

H. First-aid kits and first-aid manuals shall be readily available to staff in a designated location in all Organization sites where licensed services are provided.

I. A documented safety review shall be conducted by the Organization every six (6) months to ensure that each Organization site where licensed services are provided is free of hazards. The documentation shall include dates of inspections, name of the person(s) by whom the inspections are conducted, identification of areas inspected, any corrective actions taken in response to deficiencies cited, and dates inspections were completed.

J. All the Organization sites where services are provided shall meet the State Fire Code requirements for such facilities and/or occupancies.

1. It is the responsibility of the Organization to ensure that each licensed site has received initial and routine fire and life safety inspections that meet the approval of the Office of the State Fire Marshal.

2. It is the responsibility of the Organization to communicate with the Office of the State Fire Marshal and comply with the State Fire Code, including but not limited to scheduling re-inspections after a violation(s) is resolved.

3. It is the responsibility of the Organization to ensure that each licensed site shall have on-site fire extinguishers, smoke detectors, and any other fire detection and suppression system(s) required by law.

4. All flammable and combustible materials shall be properly labeled, stored, and locked in accordance with the State Fire Safety Code.

K. All toxic materials including but not limited to poisons, chemicals, and pesticides shall be:

1. Properly labeled.

2. Stored in original container separate from all foods, food preparation utensils, linens, and medications.

3. Stored in a locked area.

L. The temperature within premises shall be maintained within a normal comfort range. During times of extreme summer heat, the Organization shall make reasonable efforts to keep individuals comfortable using ventilation, fans, or air conditioning.

M. Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition and shall be properly stored.

N. Hazardous cleaning solutions, compounds, and substances shall be labeled, stored in a safe place and kept in an enclosed section separate from other cleaning materials.

O. The Organization shall comply with all applicable federal, state, and local governmental safety and sanitation laws, rules and regulations.

7.3.2 Management of Information

A. The Organization shall plan, design, and maintain information management processes to meet internal and external information needs and requirements.

B. The information management process established and maintained by the Organization, whether manual and/or electronic, shall, at a minimum:

1. Coordinate the collection of information.

2. Organize data.

3. Interpret and clarify data.

4. Generate and provide access to longitudinal data.

C. The Organization shall have and maintain the ability to report children's data electronically to the Department for such purposes as the Department deems necessary, as required by state and federal laws and regulations, or as required by funding or oversight entities.

D. The Organization shall establish and maintain children's records and electronic data in such a manner as to make uniform the system of periodic reporting that may be required by the Department.

E. The Organization shall provide any and all requested information, both routine and nonroutine, as specified by the Department.

F. The Organization shall define, capture, analyze, transform, transmit, and report individual-specific data and information on treatment or services and outcomes pursuant to applicable federal and state laws and regulations.

G. To the extent possible, the Organization shall utilize uniform data definitions and data capture methods.

H. The Organization shall establish and maintain data integration and interpretation capabilities necessary to meet the requirements of this subsection.

I. The Organization shall establish and maintain an organized system for disseminating information to appropriate stakeholders, including but not limited to the Department, as required by this Chapter, and pursuant to state and federal laws and regulations.

J. The Organization shall ensure that the transmission of data and information is timely and accurate.

K. To the extent possible, and as required by this Chapter, the Organization shall establish and maintain standardized formats and methods for disseminating data and information.

7.3.3 Protection of Information

A. Records and information collected and/or maintained by the Organization shall be protected against loss, destruction, tampering, and unauthorized access or use.

B. The Organization shall maintain a written policy regarding proper transfer or disposal of records of service recipients consistent with applicable state and federal laws and regulations.

C. CBHOs shall have explicit policies and protocols to ensure that all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider.

1. All information and data required by the Department shall be collected, maintained, and submitted to the Department in compliance with all state and federal privacy and confidentiality laws and regulations, including but not limited to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 C.F.R. Part 2; the Confidentiality of Health Care Information Act, R.I. Gen Laws § 5-37.3-1, et seq.; the Mental Health Law, R.I. Gen. Laws §§ 40.1-5; and any other relevant federal and state laws and regulations, including those that address patient privacy requirements specific to the care of minors.

D. The Organization is required to maintain continuous, reasonable and appropriate security protections, safeguards, policies, and procedures regarding client and staff records, including electronic or paper charts containing PHI.

E. The Organization is responsible to physically safeguard records, such as through the use of locked cabinets or offices. CBHOs must also protect records electronically, such as using secure and up-to-date passwords or key-code protections.

1. If an Organization chooses to utilize electronic mail, the Organization shall provide Organization assigned, secure, and encrypted email addresses to staff that maintain data security. Staff shall not use personal email addresses to communicate Organization information.

2. Email correspondence must remain confidential and HIPAA compliant.

F. The Organization's safeguards shall allow access and availability to authorized personnel, while restricting access and availability to unauthorized persons.

1. The safeguards must be relevant to the creation, acquisition, dissemination, examination, disclosure, transfer, storage, removal, disposal, use, and re-use of all records, including those with PHI.

2. CBHOs must provide for appropriate and recurrent training, authorization, and supervision of workforce members who work with PHI.

G. The Organization must have and apply appropriate sanctions against workforce members who violate its policies and procedures in accordance with state and federal laws.

7.3.4 Service Records

A. The Organization shall maintain a treatment record for every child assessed, treated, or served and incorporate information into the treatment record from all contacts with the child and the legal guardian.

B. Only authorized individuals shall make entries in treatment records, as specified in Organization policies and procedures, consistent with applicable state and federal laws and regulations.

C. The records of service recipients shall be maintained in accordance with all applicable state and federal laws and regulations.

D. The record of each child receiving services from the Organization shall contain the following basic information and all other relevant information including:

1. Name.

2. Address.

3. Date of birth.

4. Sex at birth.

5. Sexual orientation.

6. Gender identity.

6. Race or ethnic origin.

7. Preferred language and communication ability.

8. Education.

9. Marital status.

10. Employment.

11. Any legal status/history that would impact treatment planning.

12. The name and phone number of any legally authorized representative.

13. Dates of screening, intake and discharge.

14. Information about the person to contact in the event of an emergency, including such person's name, address, and telephone number(s).

15. Documentation of all referrals and communications made to external community service providers.

16. Signed documentation by a child and/or legal guardian, as required by law, for consent to treatment and services, documentation of refusal to consent to treatment or service, or withdrawal of such consent. If the child and/or guardian, as required by law, consents to treatment and services but refuses to sign a consent form, such refusal shall be documented in the child's record and shall not be grounds for denying treatment and services.

E. Every treatment record shall include distinct, unique child/family identifiers on every page.

F. Every treatment record entry shall be dated and signed with the author's full name and credentials.

G. The Organization shall review a random sample of service recipient records across all programs and services at least quarterly for completeness, accuracy, and timely completion of all necessary and required information, and compliance with the documentation standards of this Chapter.

H. All organization and compliance records will be maintained in accordance with EOHHS Records Retention requirements pursuant to R.I. Gen. Laws §§ 38-3-6(a), (c), and (k)(1). Confidential, sensitive, privileged, or proprietary records shall be maintained in a secure setting with restricted access to preserve the integrity of the records.

I. CBHOs are subject to requirements of HIPAA and shall have the responsibility of creating, receiving, maintaining, and transmitting physical records, including those containing protected health information (PHI) for and about clients. All children served have the right to have their records kept confidential pursuant to the applicable federal and state laws and regulations.

7.3.5 Technology

A. Organizations that choose to utilize technology to provide services to children shall have policies and procedures that support the Organization's ability to:

1. Continually assess the relative benefits and risks of providing services using technology.

2. Reasonably ensure that electronic services can meet standards of confidentiality as outlined in HIPAA, HITECH, and other relevant state and federal regulations, laws, and rules.

3. Confirm the identity of the client to whom services are provided electronically at the onset of each contact with the client.

4. Ensure that the provider is licensed in the State of Rhode Island.

5. Assess each individual's familiarity, comfort, needs and ability with technology, access to the Internet, language translation software, and the use of technology to meet the needs of diverse populations, such as people with differing abilities.

B. Organizations that choose to utilize technology to provide services to children shall:

1. Follow all state and federal laws, including the Rhode Island Telemedicine Coverage Act, HIPAA, and HITECH.

2. Submit to unannounced monitoring and review of policies, procedures, and records to ensure compliance.

3. Understand, comply with, and stay current with all laws that govern the provision of services utilizing technology.

4. Inform clients of the Organization's legal obligations and responsibilities.

5. Inform clients of client rights and responsibilities, as well as relevant benefits and risks, for utilizing technology, including whether and how the Organization intends to use electronic devices or communication technologies to gather, access, manage, share, and store client information.

6. Use appropriate safeguards to protect confidentiality and ensure the integrity of client information when gathered, accessed, managed, shared, and stored in a secure manner and in accordance with relevant federal and state statutes, regulations, and organizational policies.

7. Obtain and maintain training, knowledge, and skills required to provide services utilizing technology in a safe, competent, and ethical manner.

8. Provide education and support for consumers to effectively utilize technology.

9. Provide quality, accessible, and culturally competent services that are commensurate with in-person services.

10. Develop a responsible social media policy that is shared with clients.

11. Report to clients and the Department any data breaches that impact any organizational records or involve HIPAA.

12. Take reasonable steps to ensure the accuracy and validity of the organizational information that is disseminated via technology.

13. Ensure clear delineation between personal and professional communications and information.

14. Ensure that clear professional boundaries are maintained at all times.

7.4 SERVICE PROVISION

7.4.1 Initial Screening

A. CBHOs must develop and implement policies and procedures describing:

1. Clinical screening, intake, continuing care, and discharge criteria; and

2. Use of evidence-based or evidence-informed best practices.

B. The initial screening process, at a minimum, includes:

1. Collecting demographic and clinical information to determine the child's eligibility and appropriateness for a particular service.

2. Identifying and addressing the crisis, urgent and immediate needs and/or concerns of the child and family, including risk and safety across critical domains, such as home, school, and community; and

3. Determining the need for further assessment or plan of care, either by the Organization or by referral to another provider or organization.

C. The Organization has written policies and procedures describing the initial screening process and collection of information necessary to complete the screening. As feasible and voluntarily provided, information collected and recorded must include:

1. Contact and demographic information, such as race, ethnicity, preferred language, sexual and gender identity, disability status, and other relevant factors.

2. Social, medical, developmental, and any relevant history helpful in determining a child 's need for services, including the child's use of alcohol and other drugs; past or current mental health diagnoses; and past or present medical diagnoses.

3. Presenting challenges, current functioning and relevant concerns.

4. Risk and safety factors, including suicidal or homicidal ideation, self-harm, abuse or neglect, trauma, child sexual exploitation, and serious emotional disturbances or behaviors leading to impairment across areas of functioning at home, school, or in the community to determine the need for emergency or urgent care.

D. The Organization has written policies and procedures that describe the process for determining the appropriateness for intake during the initial screening that shall include:

1. Criteria for determining a child's eligibility for programs or services, including use of and management of waitlists.

2. Criteria to prioritize the scheduling of appointments.

3. Criteria for denying services.

4. Procedure for referring to other providers.

E. When a child is found to be eligible for the Organization's services but not in need of immediate or crisis-related services, an appointment is scheduled with reasonable promptness. If the Organization lacks the resources to schedule an intake appointment within twenty (20) business days of the screening date, the Organization offers referrals to another appropriate provider and documents the referral. If a waitlist is offered, the family may choose to remain on a waitlist and/or pursue services with another provider. CBHOs that are also CCBHCs may have additional or different requirements as listed in § 7.5.2 of this Chapter.

F. When the screening results in a child not being offered services by the Organization, the following procedures, at a minimum, are implemented:

1. The CBHO provides recommendations for alternative services and providers.

2. The child and legal guardian, as required by law, are informed that they may speak with the screening supervisor if they state their situation has not been adequately understood.

3. The child and legal guardian, as required by law, are informed that complaints may be directed to the Department, per § 8.2.16 herein.

4. The Organization maintains documentation of these actions.

G. Staff conducting initial screenings shall:

1. Have access to current information about available programs and services offered by the Organization, including approximate wait times before an intake can occur and services can begin.

2. Be adequately trained and supervised in the CBHO's intake process to effectively collect necessary intake data and communicate follow-up steps to legal guardians and children.

3. Be trained in and able to identify during a screening the need for immediate response and use basic crisis de-escalation skills.

4. Be able to articulate the procedure the CBHO follows to ensure the referral is screened for an appropriate service type and why or when a service, support, treatment, or program may not accept a child.

5. Have access to current information about appropriate, alternative services and supports for which a child or legal guardian can be referred.

7.4.2 Intake

A. Each CBHO maintains written intake process, policies, and procedures available to staff, families, children, and the Department for review.

B. The policies and procedures define the roles and responsibilities of each participant in the intake and the service provision process, as well as identify specific goals and objectives expected for participation in the program or service.

C. Intake procedures include collection of necessary documentation per § 8.4.2 (E) herein to begin services, biopsychosocial assessment, and planning for follow-up.

D. The Organization ensures that staff conducting intakes have the following knowledge and understanding at a minimum:

1. Possess appropriate knowledge in the promotion of mental health, development, and improved functioning in children and their families.

2. Possess the skills to effectively decrease the prevalence and incidence of behavioral health conditions for children.

3. Have training, experience, and knowledge relative to the following:

a. Childhood trauma and related diagnoses.

b. Child abuse and neglect (including child sexual exploitation).

c. Child and adolescent development.

d. Family systems and family-focused plans of care.

e. Serious emotional disturbance (SED).

f. Intellectual developmental disability (IDD).

g. Substance Use Disorder screening.

E. CBHOs are required to maintain policies, procedures, and documents relative to the following and, upon intake, make them available to the child and family, as required by law or these regulations:

1. Agreement to participate/consent for treatment, including client rights and responsibilities.

2. Confidentiality policies, including applicable releases.

a. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 [1996]), 42 C.F.R. Part 2, and other federal and state laws and regulations, including patient privacy requirements specific to the healthcare of minors.

3. Consent for photography.

4. Crisis evaluation, planning, and response.

5. HIPAA and use of PHI.

6. Mandatory reporting.

7. Organization's method of managing and prioritizing client needs and timeframes for providing services.

8. Organization's method of managing a client's lack of participation after commencing a service (e.g., non-compliance, no shows, chronic cancellations).

9. Requirements and acceptable methods of payment and/or insurance coverage.

10. Use of behavioral management techniques, including restraints, if the CBHO is approved by the Department to utilize restraints and such techniques may be used within the program/service a child may be receiving. A legal guardian must agree to any use of restraints. See § 8.4.10 herein for additional information on Prohibited Practices.

F. If the Organization lacks the resources to begin services within fifteen (15) business days after the intake date, the Organization offers referrals to another appropriate provider and documents the referral. If a waitlist is offered, the family may choose to remain on a waitlist and/or pursue services with another provider. CBHOs that are also CCBHCs may have additional or different requirements as listed in § 8.5.2 of this Chapter.

7.4.3 Comprehensive Assessment

A. An assessment of the child's physical and psychological status and social functioning is conducted by the Organization for each child who completes an intake.

1. One or more qualified staff members conduct the assessment of the child.

2. There is a written report of the assessment describing the methods and material used in the evaluation.

3. Any assessment tools used are named in the report, and any results obtained are included.

4. Information is obtained regarding the child's psychological, developmental, medical, and familial history, including any past or current diagnoses using current DSM or ICD codes; vocational and educational status and academic achievement; social and emotional background and status; substance use, including history; the presenting problems causing impairment across key life domains; and any other relevant information.

5. The person responsible for writing the assessment, as well as the licensed practitioner supervising the development of the assessment under the scope of their license (if a different person), must sign and date the completed comprehensive assessment within the required timeframes of specific services or programs and according to the requirements of individual licensure and provider credentialing.

B. The following is determined and documented through the assessment process:

1. Demographic information, such as race/ethnicity; preferred language; family composition and household members; sexual and gender identity; disability status; developmental history; and other relevant factors.

2. The strengths, treatment needs, goals, expectations, and other factors considered for the child receiving services.

3. Presenting concerns, chief complaints, and symptoms.

4. Risk and protective factors for the child and family.

5. The need for specialized medical, psychological, substance use, or other evaluations.

6. The elements of needed participation by the family, natural and/or formal supports, outside providers, interpreters, and other resources.

7. A medication list, including prescriptions, over-the-counter medications, herbal remedies, dietary supplements, and other treatments or medications of the child receiving services. This shall include those medications that could affect a child's clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.

8. Psychological characteristics, current mental status, acuity level and recommended level of support determination, and results of children's screenings as required by law, department regulation or evidenced-based care standards (e.g., screenings for depression, substance use disorders,

eating disorders, sexual exploitation, violence in the home, and other possible areas of concern).

9. Basic cognitive screening for cognitive impairment.

10. Assessment of imminent risk of harm, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person.

11. An overview of relevant social supports; social determinants of health; and health-related social needs such as housing status; vocational and educational history and progress; family and social supports; legal issues; and insurance status.

12. A description of cultural and environmental factors that may affect the plan of care of the child receiving services, including the need for linguistic services or supports for people with limited English proficiency.

13. Pregnancy and/or parenting status.

14. The type and level of treatment to be provided by the CBHO.

15. Assessment of the need for other services required by clinical recommendation (e.g., primary care follow-up; peer and family support services; case management; psychiatric rehabilitation services; etc.).

16. History and assessment of current behaviors associated with trauma; abuse or neglect; sexual exploitation; alcohol and substance use; or other behavioral health conditions and diagnoses. Behavioral health history includes information about past and current therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.

17. Assessment of potential for clinically appropriate use of restraints.

18. Assessment of any relevant child welfare or juvenile justice involvement and referral to child welfare agencies, as appropriate.

C. The information obtained through comprehensive assessment determines and informs the child's plan of care. Each comprehensive assessment includes an integrated summary that analyzes and synthesizes the findings of the assessment. Formulation of the integrated summary includes:

1. A description of the child that includes strengths, aspirations, and concerns related to the proposed treatment or plan of care.

2. Formulation and prioritization of the concerns for treatment or plan of care and a description of the factors that contribute to each concern.

3. Clinical judgments regarding both positive factors and challenges likely to affect the child's course of treatment and clinical outcomes.

4. Current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses or International Classification of Diseases (ICD) codes, written and coded.

5. For children assessed to need further substance use assessment or services, evidence that the provider can provide such services or that the child has been referred to an appropriate provider.

D. For children with intellectual developmental disabilities, the comprehensive assessment shall additionally include a functional behavior assessment.

E. A comprehensive assessment shall be required for all children receiving CBHO services. The comprehensive assessment shall be completed within thirty (30) days of intake.

F. The comprehensive assessment is reviewed and updated at least once every twelve (12) months. The comprehensive assessment is additionally reviewed and updated when there is a significant change that may impact the plan of care. This review must be timely, documented, and signed by both the person completing the assessment and the licensed practitioner supervising the development of the assessment (if a different person) within the Organization's required time frames for specific services or programs.

G. Comprehensive assessments, as well as plan of care updates and reviews, shall involve face-to-face meetings with the child receiving services.

7.4.4 Plan of Care

A. Plan of Care – Development and Review

1. All CBHOs shall provide child-guided and family-centered plans of care for children, including risk assessment and crisis planning, as necessary.

2. The plan of care development shall be coordinated with staff members or programs necessary to implement the plan. The plan shall provide for care for children in the least restrictive setting appropriate and available to meet the needs of the child receiving services. Shared decision making is the preferred method for developing the plan of care.

3. All legally required releases of information shall be included in the child's treatment record as a part of the development of the initial plan of care and updated as required by law.

4. The treatment team shall seek consultation during the development of the plan of care to address the need for specialized services, including but not limited to eating disorders, traumatic brain injury, intellectual developmental disabilities (IDD), interpersonal violence and human trafficking, as appropriate.

5. The treatment team, in collaboration with the child receiving services and the legal guardian, as required by law, shall, following a psychiatric emergency or crisis, ensure the plan of care is updated to address the causes, impact and/or outcomes of the crisis to prevent and de-escalate future crisis situations.

6. The CBHO plans with the child and family, as appropriate, to:

    a. Assess the child and make recommendations for any additional services.

    b. Provide services to the child and family and integrate natural or peer supports, as appropriate.

    c. Coordinate and support any changes in applicable services.

    d. Support the goals, treatment, and programming needs for the child and family.

    e. Provide transition and discharge supports, treatments and programming that align with the child and family's needs, strengths, goals, and achievements.

    f. Provide referrals to additional services, as appropriate.

7. Based on the comprehensive assessment, a strength-based, goal-oriented, culturally sensitive, child and family-guided, child-focused, time-limited, and individualized plan of care shall be developed by day thirty (30). Ongoing screening and assessment shall be documented in the child's plan of care and progress notes, as required by law and/or CBHO policy.

8. The plan shall be developed in collaboration with and be endorsed by the child receiving services; their family, to the extent the child receiving services so wishes; and family or legal guardians. Minors sixteen (16) and over may consent to treatment as provided in R. I. Gen. Laws § 23-4.6-1.

9. The plan of care shall include provisions for monitoring progress in achieving the child's identified goals.

10. The plan of care shall address substance use, if identified as a treatment need, and document appropriate interventions or referrals, if necessary, to address a substance use disorder. CBHOs who wish to provide substance use services for children and adults must attain a BHO license per 212-RICR-10-10-01.1(A).

11. At minimum, the plan of care for children shall be reviewed and updated at minimum every ninety (90) days.

12. For CBHOs that are certified as CCBHCs, there may be additional or different regulatory requirements for completion of the plan of care.

B. Plan of Care – Contents: The child's plan of care shall address and incorporate:

1. The child's unique needs, expectations, and characteristics, including child and family history, strengths, and culture and background, that are to be used to build an appropriate, personalized, and comprehensive plan. The plan of care shall specify measurable and time-bounded goals and objectives to be achieved by the child and family, as appropriate, to establish or re-establish emotional health and well-being within a family system.

2. Written and coded diagnoses from the current edition of the DSM and/or current ICD codes demonstrating a clear connection between the diagnoses, the data, and the integrated summary documented in the assessment and the goals and interventions identified on the plan of care.

3. A written statement of each need identified through assessment, a statement of which need will be addressed by which treatment plan component(s), and in what order of priority.

4. Observable and measurable long and short-term goals as formulated with the child and family served.

5. Interventions, services, tasks, or supports needed to attain goals:

    a. When and with what frequency each intervention will occur.

    b. An identified person(s) who will perform each intervention.

6. Clear evidence of child and family voice and choice in developing the plan.

7. Timeframes based on the projected length of time to review progress or to accomplish each specific goal and intervention.

C. A professional staff member who has the clinical skills and experience to provide the indicated services must be responsible for the overall development, implementation and maintenance of the plan of care. This staff member is clearly identified in the plan. The plan must be reviewed and validated with the signature of the licensed practitioner overseeing its development within the scope of their license.

D. The plan of care is dated and includes the signatures of the child and legal guardian, as required by law. Unless the primary provider meets the qualifications in § 7.2.26(I) of this Part, the plan of care is validated with the signature of the licensed practitioner overseeing the development of the plan. Each staff person's credentials and the date signed are clearly documented. If the child is unwilling or unable to sign, a statement as to unwillingness or inability and clinical signature shall be documented.

7.4.5 Treatment, Service, and Plan of Care Review

A. The child-guided and family-centered plan of care shall be reviewed and updated as needed, in agreement with and endorsed by the child receiving services. Each plan of care is reviewed at a minimum every ninety (90) days.

B. The plan of care review shall evaluate and document the progress or lack thereof toward the established goals and objectives and revise the plan of care accordingly. The plan of care shall be updated and modified, as necessary, at each of the following events:

1. At the time of the child's intake to a specific service or program.

2. Upon changes in the child's condition or level of care.

3. At the time of an internal transfer between programs.

4. When an intervention is completed or a goal is attained.

5. When an intervention is not helping the child to attain the desired outcome.

6. Upon the child's frequent use of crisis intervention services.

7. If a child refuses services or is not available for services.

8. Following significant events in a child's life.

9. At the child or family's request

C. This update must be reviewed and validated with the signature of the licensed practitioner overseeing its development under the scope of their license according to requirements specified in § 7.4.4 of this Part.

D. The results of the review must be specifically referenced in the child and family-centered plan of care review and are:

1. Clearly labeled or identified as a plan of care review.

2. Documented in a detailed progress note or other format that contains all the necessary elements and clearly states plan of care review.

3. Show clear evidence of being developed with the child and family based on ongoing needs, strengths, and culture and background.

E. For CBHOs that are certified as CCBHCs, there may be additional regulatory requirements for the revision of the plan of care.

7.4.6 Progress Notes

A. The child's current status and progress relative to the plan of care or treatment process are documented as progress notes in the record, including every face-to-face contact with the child and/or family.

B. Progress notes are documented according to a standard charting format (for example: subjective, objective, assessment, and plan (SOAP); data, assessment, and plan (DAP); or behavior, intervention, response, and plan (BIRP) note formats) or equivalent.

C. Progress notes provide documentation of relevant events occurring during the child's treatment process or course of treatment.

D. Progress notes shall reflect thoughtful consideration of the child and family's culture, per §§ 8.1.4, 8.1.6(LL), 8.1.6(SSS) and 8.2.24(B)(1)(f)(5) herein.

E. Progress notes must contain the following:

1. Information about the child's progress in the treatment process toward achieving treatment goals.

2. Type and duration of service.

3. Discussions pertaining to the informed decision-making process for the child and family.

4. Decisions made by the child and family.

5. Information about children and families present during face-to-face visits and/or treatment, including ancillary services used to include interpretation services, natural supports, and supplementary services.

6. Cancelled and missed appointments.

7. Reasons for discharge.

F. All records, entries, and documentation required by these regulations shall be:

1. Prepared at the time, or immediately following, the event being recorded.

2. Reflective of active engagement, including attempted service provision.

3. Accurate, complete, concise, and devoid of willful falsifications.

4. Legible, dated, and signed by the person making the entry and endorsed by the clinical supervisor, as required.

5. Coded correctly for billing purposes.

6. Maintained in accordance with EOHHS Records Retention requirements pursuant to R.I. Gen. Laws § 38-3-6(a), (c), and (k)(1).

7.4.7 Transition/Discharge Summary and Aftercare Plan

A. Planning for transition/discharge and aftercare is a process that begins upon intake.

B. A transition/discharge and aftercare plan shall be developed in partnership with the child and family in a planned manner before discharge. The plan of care team receives a copy of the plan.

C. The aftercare plan includes:

1. Services to be accessed following transition/discharge.

2. Activities to sustain the progress made during treatment.

3. A crisis evaluation or plan for the child and family to follow after transition/discharge, when indicated.

D. A transition/discharge summary is formulated and reflects the most significant information regarding the child's plan of care and progress from the time of first contact up to the child's discharge from service. Transition/discharge plans shall include a child's or family's concerns and social risk factors, including those related

to housing, food security, recovery and relapse services, finances, health care, transportation, occupational and education concerns, as well as social supports. The treatment team implementing the child's transition/discharge plan ensures that the above concerns and planned aftercare are documented in the child's record.

E. The summary is completed within the Organization's required time frames for specific services and programs during the process of the child's discharge from the Organization. The summary shall be completed no later than fifteen (15) business days after the child's discharge from the Organization.

F. The transition/discharge summary includes the following:

1. Circumstances of the discharge.

2. Ongoing presenting concerns.

3. Current DSM diagnoses or ICD codes, written and coded.

4. All significant findings relevant to the child's plan of care.

5. Course and progress of treatment.

6. Outcomes in relation to the identified concerns, goals, and plan of care.

7. List of current medications.

8. List of providers involved in the child's care at the time of discharge, including state agencies.

9. Recommendations and referrals for further services, including medication management and/or other state agency involvement, if indicated.

7.4.8 Behavior Management

A. The Organization is required to develop, implement, maintain, and review written policies and procedures that describe the use and the monitoring of behavior management interventions, if provided by CBHO staff. These policies and procedures must be consistent with applicable federal and state regulations and incorporate the following standards:

1. The Organization requires a positive approach to behavior management.

2. The least restrictive means is used in selecting a behavior management intervention.

3. Behavior management goals and objectives are integrated with the child's other goals and objectives and be in accordance with written policies and procedures that govern service expectations, treatment goals, safety, and security.

4. A behavior management agreement that is part of the child-guided and family-driven plan of care documents:

   a. The behaviors that are the target of the plan.

   b. The methods to teach appropriate expression of the targeted behavior or alternative adaptive behavior.

   c. The procedures to be used.

   d. How often, under what circumstances, and by whom the plan will be implemented and executed.

   e. The intended result of the behavior management interventions.

5. Other individuals served by the Organization are not requested or assigned to carry out any element of the child behavior management plan.

B. All behavior management plans are developed, implemented, and monitored by employees or contractors trained in behavior management.

C. Use of behavior management interventions as described in §§ 8.4.8 and 8.4.9 herein require the written consent of the legal guardian for the child served. As appropriate, the child and legal guardian shall participate in selecting behavior management interventions with the treatment team.

D. The child and family served have the right to withdraw their agreement to an aspect, or all parts, of a behavior management plan, and to be advised of the potential risks and impact on their treatment.

E. The Organization identifies, educates, and approves those staff who are responsible for the development, implementation, and maintenance of behavior plan of care.

F. CBHO policies and procedures specify the mechanism for monitoring the use of behavior management, subject to contractual and statutory requirements.

G. CBHO policies and procedures related to behavior management are provided to children and families served, and, as appropriate, to their care team and advocates.

H. Prohibited interventions for all CBHOs are listed herein at § 8.4.10.

7.4.9 Behavioral Intervention and Physical Restraint

A. If a CBHO foresees a need to engage in a physical restraint or physical restriction of movement within the treatment space, permission to do so as a matter of procedure shall be requested in writing in advance and approved by the Department. Such written request shall include a detailed rationale for why restraint may be unavoidably necessary to ensure immediate individual health and safety. All restraint or physical intervention-related policies and procedures shall be submitted to the Department as part of the approval process and when changed in any way. A CBHO is prohibited from engaging in a physical restraint or other physical restriction on movement within the treatment space unless the policies and procedures for doing so are expressly approved by the Department.

B. Prior to engaging in behavioral interventions, the CBHO shall develop Behavioral Intervention Policies and Procedures, including those related to the use of physical restraints. Such policies, at a minimum, shall include staff training requirements, positive clinical strategies, crisis prevention, and intervention procedures to be used to keep participants and others safe.

C. The Behavioral Intervention Policies and Procedures shall utilize evidence-based, positive behavior management strategies and interventions to reduce the ongoing use of emergency restraints or restrictions on a child's rights. Such policies shall also include clear guidelines for:

   1. Determining the need to develop a behavior support plan and

   2. How changes shall be made to the Behavioral Support plan.

D. All behavioral intervention plans shall conform to and abide by Children's Freedom from Restraint Act, R.I. Gen. Laws Chapter 40.1-26.3.

E. All staff utilizing any behavioral interventions and restraints shall be trained on a nationally recognized model of crisis intervention and physical restraint.

F. When a behavioral intervention or physical restraint is identified as a potential need for a child, CBHOs are required to develop and implement a positive behavioral support plan, documented in the plan of care, with strategies that:

   1. Support and promote the child's strengths, needs, and preferences.

   2. Are evidence-based, effective, and ethical.

   3. Are child and family-centered.

   4. Are the least restrictive.

5. Are provided in the most integrated setting utilizing inclusive service delivery.

G. Non-physical interventions are the first choice as an intervention unless safety concerns demand an immediate physical response. Physical restraint, as defined in this Part, may be used only when there is an imminent risk of harm to the child or others and no other safe and effective intervention is possible.

1. When physical restraint is used, it is applied in a manner that minimizes the possibility of physical injury or mental distress to the child.

3. Only approved physical restraining procedures and models developed by a nationally recognized organization and approved by the state are to be used. All staff members administering a restraint must be fully trained in the restraint method.

3. No staff can lay across the back of a participant in a hold. The child served is never placed in a prone restraint, as prohibited by the Freedom from Prone Restraint Act, R.I. Gen. Laws § 42-158-4.

4. The child is removed from restraint as soon as the threat of harm has been safely minimized.

H. Restraints shall never be employed as punishment, for the convenience of staff, or as a substitute for an individualized plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the participant and shall be designed to allow the greatest possible comfort, pursuant to Rights for Persons with Developmental Disabilities, R.I. Gen. Laws § 40.1-26-3 (8).

I. Restraints shall be subject to the following conditions:

1. Physical restraint shall be used to protect the child or others from imminent injury.

2. Any restraint that is conducted shall be in accordance with state statute.

3. Any restraint that is conducted shall also be in accordance with the Children's Freedom from Restraint Act, R.I. Gen. Laws 42-35-3.2.

J. For purposes of this Part, prohibited restraints shall not include the following:

1. Therapeutic Restraint shall be acceptable when it is applied as the use of a staff member's body to immobilize or reduce the free movement of a child's arms, legs, torso or head to ensure the physical safety of a child or other individual at the site. The term does not include either brief holding of a child

in order to calm or comfort or the minimum contact necessary to safely escort a child from one area to another.

2. Practices or devices that protect the child or permit the child to participate in activities without the risk of physical harm (e.g., straps on a wheelchair that stabilize the child; helmets; gear utilized to protect a child from injury from a fall or self-injury, etc.) when such devices are documented in the child's plan of care and are the least restrictive means available to prevent harm or self-injury.

3. Such devices that include child restraint systems as defined by R.I. Gen. Law 31-22-22 or devices ordinarily worn by the child during transport, for medical immobilization, adaptive support, or medical protection. Age and developmentally appropriate protective safety interventions (such as a stroller, swing or highchair safety belts, raised crib rails and crib covers) that a safety-conscious provider would utilize to protect a child shall not be considered restraints.

K. Post Intervention Debriefing: Within twenty-four (24) hours after the use of restraint:

1. Staff involved in an emergency safety intervention shall have a face-to-face discussion with the child.

   a. The discussion shall include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the child. (Other staff and the child's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the program.)

   b. The CBHO shall conduct such a discussion in a language that is understood by the child's parent(s) or legal guardian(s).

   c. The discussion shall provide both the child and the staff with the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, child, or others that could prevent the future use of restraint or seclusion.

2. Staff involved in the emergency safety intervention and appropriate supervisory and administrative staff shall conduct a debriefing session that includes, at a minimum, a review and discussion of:

   a. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention.

b. Alternative techniques that might have prevented the use of the restraint.

c. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint.

d. The outcome of the intervention, including any injuries that may have resulted from the use of restraint.

3. Staff shall document in the child's record that both debriefing sessions took place and shall include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the child's plan of care that result from the debriefings.

4. Restraints shall be reported as Reportable Incidents to the Department according to § 8.2.23 (E) herein.

L. In addition to those prohibited under R.I. Gen. Laws §§ 40.1-26-3, 40.1-26-4.1, and 42-158-4, the following procedures shall be specifically prohibited from use under any circumstances:

1. Utilizing law enforcement in lieu of a clinically approved therapeutic emergency intervention or behavioral treatment program.

2. Utilization of behavioral interventions for the convenience of the staff.

3. Utilization of behavioral interventions for any reason except for emergency protocol.

7.4.10 Prohibited Practices

A. The following practices are strictly prohibited during the course of a CBHO's work with a child or family. This restriction does not contraindicate any state or national licensure standards; any certification requirements; any state contractual requirements; or individual program standards.

B. Prohibited practices in all CBHOs include but are not limited to the following:

1. Aversive techniques, as defined in § 8.1.6 herein, are prohibited in all CBHOs and by all CBHO personnel, including but not limited to the following:

a. Using or withholding food as a punishment or reward, unless specifically stated in the child's plan of care.

b. Forcing the child to eat or drink.

c. Restricting the child from eating or drinking.

d. Toilet or hygiene training methods that punish, demean, or humiliate a child.

e. Forcing the child to use the bathroom.

f. Restricting the child from using the bathroom.

g. Rejecting, terrorizing, ignoring, isolating, or corrupting a child.

h. Using abusive, profane, or sarcastic language; verbal abuse; threats; or derogatory remarks to the child or family or about the child or the child's family.

i. Engaging in any form of public or private humiliation, including threats of physical punishment.

j. Withholding essential services or communication.

k. Destroying or unreasonably withholding a child's personal property.

l. Corporal punishment as defined herein is strictly prohibited at all times.

m. Chemical or Pharmacological Restraint.

n. Mechanical Restraint.

2. Other practices that are strictly prohibited include but are not limited to:

a. Smoking and the use of tobacco products at the CBHO site, on CBHO site grounds, or while providing CBHO services to children within the community, including smoking in any vehicle used by the CBHO staff or personnel for transporting children.

b. Possessing, using, or being under the influence of recreational or illegal drugs or alcohol while providing CBHO services at the CBHO site, on grounds, or while providing CBHO services to children and families within the community.

c. Possessing or using firearms, weapons, or dangerous instruments of any kind in the CBHO site, on CBHO site grounds, or while providing CBHO services to consumers within the community.

d. Engaging in any relationship with the child of a physical or personal nature that crosses professional or ethical boundaries.

e. Denying the child's legal rights.

7.5 Services and Program Types

7.5.1 Emergency, Crisis Intervention, and Crisis Stabilization Services

A. Children's Emergency Service and Mobile Response and Stabilization Services can only be delivered by licensed CBHOs.

B. CBHOs that provide children's emergency, crisis intervention, and crisis stabilization services are required to be licensed under and are subject to the requirements of the Mental Health Emergency Service Interventions for Children, Youth and Families Regulations for Licensure, 214-RICR-40-00-6.

C. All CBHOs designated as CCBHCs are required to operate a crisis intervention and stabilization program, either through direct service or a Designated Collaborative Organization (DCO) agreement, for children and their families who reside in the designated service area of the CCBHC per § 8.5.2(T) herein.

7.5.2 Certified Community Behavioral Health Clinic (CCBHC)

A. The Certified Community Behavioral Health Clinic (CCBHC) system is designed to achieve improved outcomes and ensure access to needed care and treatment for individuals who experience symptoms of behavioral health disorders. Improved outcomes are achieved through the use of evidence-based and trauma-informed practices and protocols.

B. These regulations put into effect the federal and state certification standards that create the Certified Community Behavioral Health Clinic (CCBHC) system and outline the process and requirements for licensing CCBHCs, pursuant to the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), § 223, as expanded under § 11001 of the Bipartisan Safer Communities Act (BSCA) of 2022 and R.I. Gen. Laws § 40.1-8.5-8.

C. In the event of a conflict between CBHO and CCBHC requirements, the provisions that are specific to CCBHCs shall prevail as they relate to CCBHCs.

D. Eligibility for CCBHC licensure: To be licensed by the Department as a CCBHC provider of clinical and other services to children and their families, each applicant shall meet the following minimum requirements:

1. Comply with all applicable state and federal statutes, regulations, and certification standards.

2. Meet the criteria established by § 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA) and the State of Rhode Island.

3. Be accredited by one of the following nationally recognized accreditation bodies: The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation with standards specific to the delivery of developmentally appropriate behavioral healthcare services for children and their families.

4. Have and maintain all necessary state-required licenses, certifications, registrations, or other credentials. When CCBHC and DCO service providers are working toward licensure, appropriate supervision shall be provided in accordance with applicable state laws.

5. Have a minimum of three (3) years of demonstrated experience providing evidence-based practices for children the CCHBC is serving – including children experiencing mental or behavioral health conditions and serious emotional disturbance (SED)~~;~~ or intellectual developmental disabilities – or demonstrated experience providing child and family-centered,~~–~~and trauma-informed care to children.

6. At the time of application, the applicant shall be delivering CCBHC-required services to children as described in R.I. Gen. Law § 40.1-8.5-8 and § 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA) or be approved to add CCBHC-required services for children pursuant to a request from the applicant prior to issuance of a CCBHC license.

E. Licensing requirements

1. An applicant that wishes to provide clinical services to children as a CCBHC shall apply for a CBHO/CCBHC license, in accordance with 212-RICR-10-00-1, Licensed Organizations and § 7.5.2 herein.

2. Any provider seeking to deliver clinical services on behalf of a CCBHC as a DCO must also obtain a CBHO license for the services they intend to deliver.

3. Any provider, including DCOs, of non-clinical CCBHC services, which include but are not limited to outreach and engagement, is not required to obtain a CBHO license.

4. A CBHO that has been issued a CBHO/CCBHC license by the Department shall not operate as a CCBHC unless and until the CCBHC has received Medicaid certification from EOHHS and BHO licensure from BHDDH to operate as a CCBHC.

5. At the time of application for a CCBHC license, the applicant Organization shall submit the staffing plan of each children's service delivered by the CCBHC or by a DCO, as allowed, detailing the positions and required credentials for each position and whether the positions are currently filled or vacant. Such staffing plan is subject to approval by DCYF for services for children.

6. Each applicant seeking licensure as a CCBHC shall provide the Department with a completed community needs assessment for the service area in which it intends to provide children's services. This assessment must be conducted by the applicant or in collaboration with other community stakeholders, and it shall identify current conditions and desired services or outcomes based on data and input from key community stakeholders. The needs assessment must be updated regularly and, at a minimum, once every three (3) years. The community needs assessment shall include the following elements as they pertain to children and their families:

    a. A description of the physical boundaries and size of the service area, including identification of sites where children's services are delivered by the CCBHC, including through DCOs.

    b. Information about the prevalence of mental health and related needs for children in the service area.

    c. Economic factors and social determinants of health affecting children's access to health services, such as percentage of families with incomes below the poverty level, access to transportation, nutrition, and stable housing.

        (1) Cultures and languages of children and families residing in the service area.

        (2) The identification of the underserved child and family population(s) within the service area.

        (3) A description of how the staffing plan does and/or will address findings.

        (4) Plans to update the community needs assessment at least every three (3) years that shall include components related to children and their families.

    d. Input from required entities as described in §§ 8.5.2 (E)(6)(i) and (j) herein with regard to:

(1) Cultural, linguistic, physical health, and behavioral health treatment needs.

(2) Evidence-based practices and behavioral health crisis services.

(3) Access and availability of CCBHC services including days, times, and locations, and telehealth options.

(4) Potential barriers to care such as geographic barriers, transportation challenges, economic hardship, lack of culturally responsive services, and workforce shortages.

e. Input from the following entities, if they are in the CCBHC service area:

(1) Children and families with lived experience with behavioral health conditions and children who have received or are receiving services from the clinic conducting the needs assessment.

(2) Health centers (including Federally Qualified Health Centers in the service area).

(3) State and local health departments.

(4) Inpatient children's psychiatric facilities, children's inpatient acute care hospitals, and children's hospital outpatient clinics.

(5) Representatives from local K-12 school systems.

(6) Children's crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers, and warmlines.

f. CCBHCs must engage with other children's community partners, especially those who work with children receiving services from the CCBHC and populations that historically are not engaging with health services, such as:

(1) Organizations operated by individuals with lived experience with behavioral health needs.

(2) Other mental health and SUD treatment providers in the community who provide care to children.

(3) Juvenile justice agencies and facilities.

(4) Indian Health Services related to children or other tribal programs such as Indian Health Service youth regional treatment centers, as applicable.

(5) Child welfare agencies and state-licensed and nationally accredited child placing agencies for therapeutic foster care service.

(6) Peer-run and operated service providers.

(7) Homeless shelters and housing agencies.

(8) Other social and human services; for example, domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, and food and transportation programs.

F. Implementation

1. In addition to federal CCBHC Certification Standards, CCBHCs shall comply with Rhode Island-specific CCBHC requirements for children as delineated in this Part.

2. CCBHCs shall comply with the provisions of R.I. Gen. Laws §40.1-8.5-8.

3. The CCBHC services and programs for children shall be organized and coordinated to maximize accessibility and client flow among services and programs provided, at a minimum, to the populations specified in § 7.5.2(D)(5) of this Part, consistent with the role of the CCBHC as a fixed point of accountability for clinical care. This responsibility shall include but is not limited to ensuring the transition between children's services and access to additional children's services needed and provided by the applicant.

4. The CCBHC shall have a training plan that includes all CCBHC employed and contracted staff who have direct contact with children receiving services or their families.

5. The CCBHC shall provide professional treatment for children experiencing the effects of trauma by employing or contracting with professionals who possess expertise in the treatment of trauma in children.

6. When the CCBHC staff does not have the necessary expertise to meet the needs of a child seeking or receiving services, the CCBHC shall make a referral for specialized behavioral health services, including but not limited to treatment for sexual trauma, eating disorders, and neurological testing.

G. Designated Collaborating Organizations (DCOs)

1. The CCBHC shall provide services directly or through formal agreements with DCOs, care coordination agreements, and referrals to other providers for children. CCBHCs shall have a formal written agreement, contract, or Memorandum of Understanding with any DCO it has engaged to provide one or more of the nine (9) required CCBHC services pursuant to federal Substance Abuse and Mental Health Services Administration (SAMHSA) criteria.

    a. The formal written agreement shall contain provisions that stipulate that the requirements of CCBHC children's services that the DCO provides under the terms of the agreement shall be delivered in a manner pursuant to these regulations and any other federal and state laws and regulations.

    b. The formal agreement shall clearly articulate the role and function of the CCBHC and DCO in developing treatment and care coordination plans for children receiving services from the CCBHC and that the CCBHC coordinates clinical care and services provided by the DCO in accordance with the current plan of care.

    c. If a CCBHC and DCO relationship is materially altered throughout the course of a CCBHC program year, including the termination of the agreement or a change in service responsibilities, the CCBHC shall notify the Department, BHDDH, EOHHS and their MCO partners within ten (10) days of any such material alteration.

2. A DCO providing any clinical services for children for a CCBHC shall obtain and maintain a CBHO license and any other applicable licenses, certifications, or credentials prior to providing services.

    a. A DCO that has a formal agreement with a CCBHC to provide CCBHC clinical services for children shall have a minimum of three (3) years of experience providing such service type or treatment modality, unless written approval to waive this requirement is obtained from the Department.

    b. CCBHCs shall require a copy of the proposed DCO staffing pattern for any services provided pursuant to a formal written agreement, contract, or Memorandum of Understanding (MOU) with the CCBHC. The staffing pattern shall detail the positions and required credentials for each position and shall specify whether the position(s) are currently filled or vacant.

    c. The CCBHC remains fully responsible for ensuring that any services delivered by a DCO meet the clinic's established standards for quality,

accessibility, and clinical care. This includes ongoing oversight to verify that DCO services are delivered safely, effectively, and in alignment with the expectations outlined in formal agreements, contracts or MOUs.

d. CCBHCs shall ensure that all children's services are provided in a manner aligned with the requirements of § 2402(a) of P.L. 111-148, including those provided by a DCO with whom it has a formal written agreement, contract, or MOU.

e. DCOs shall only provide those children's services authorized by the Department consistent with the requirements in the federal CCBHC Certification Standards and this Part.

f. DCO-provided services for children attributed to a CCBHC shall meet the same quality and access standards as those provided by the CCBHC.

(1) Any DCO that directly provides emergency services shall be licensed by the Department as a provider of children's emergency services per § 8.5.1 herein and 214-RICR-40-00-6.

(2) If a DCO provides a twenty-four (24) hour crisis line or twenty-four (24) hour mobile crisis teams to children or directly provides emergency services to children, clinical staff shall include Qualified Mental Health Professionals (QMHPs) who are available to conduct an assessment.

g. The formal written agreement between the CCBHC and a DCO shall include a provision that recognizes the freedom of the child receiving services to choose providers within the CCBHC and its DCOs.

H. CCBHCs shall:

1. Develop and implement training plans for DCO staff providing children's services. Each CCBHC shall ensure that DCO staff who have contact with CCBHC clients and/or their families are subject to the same children's training requirements as the CCBHC staff for the service they are providing.

2. Provide training in applicable children's EBPs and shall monitor the DCO's use of EBPs, including training and coaching requirements, and that the EBPS are being implemented to fidelity. The Department shall have the authority to conduct fidelity evaluations of all EBPs utilizing appropriately developed fidelity measures.

3. Ensure children's DCO staff are appropriately licensed, certified, registered, and credentialed, as required by state and federal law and regulation.

4. Ensure DCO services for children are trauma-informed, family-centered, guided by child and family voice and choice, and culturally appropriate.

5. Ensure services for children provided through a DCO meet the same quality standards as those required of the CCBHC.

6. Require and ensure that DCOs collect and maintain all documentation necessary for CCBHC data collection and reporting as required by the Department, BHDDH, EOHHS, and the agreement between the CCBHC and applicable Managed Care Organizations (MCO).

7. Provide an attestation acknowledging and affirming responsibility for oversight and accountability of all children's services delivered by all contracted DCOs.

8. The CCBHC shall provide utilization management and oversight of all children's services performed by a DCO, consistent with all requirements included in this Part.

9. The Department has the authority to review the CCBHC's children's programs and services on a schedule and in a manner of the Department's choosing, not less than annually.

I. Staffing and supervision specific to CCBHCs

1. CCBHCs, including DCOs, are subject to General Staffing Requirements, found herein at § 8.2.26.

2. CCBHCs shall be subject to the following additional staffing requirements:

a. Both clinical and non-clinical staff shall be appropriate for the population receiving children's services, as determined by the community needs assessment, with respect to size and composition and providing the types of services the CCBHC is required to and proposes to offer.

b. The medical director or chief medical officer shall be board-certified or board-qualified in psychiatry and shall be knowledgeable about contemporary therapeutic and rehabilitative modalities necessary to work with the population served by the program.

(1) If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically

trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law and consistent with federal Certification Criteria (2023) requirements for alternative qualifications for a CCBHC Medical Director, may serve as the Medical Director.

(2) In addition, if a CCBHC is unable to hire a psychiatrist and instead hires another prescriber, psychiatric consultation shall be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.

(A) Such psychiatric consultation shall be provided by a board-certified or board-qualified psychiatrist or an Advanced Practice Registered Nurse (APRN), as defined under R.I. Gen. Laws § 5-34-3, who functions in the population focus of psychiatric/mental health, as defined under R.I. Gen. Laws § 5-34-3(12)(vi), and whose scope of practice is defined under R.I. Gen. Laws § 5-34-3(1), § 5-34-3(2), and § 5-34-3(15).

(3) For the position of Medical Director, whenever a CCBHC is unable to employ or contract with either of the following, any alternative shall require prior approval by the Department:

(A) A board-certified or board-qualified psychiatrist; or

(B) An Advanced Practice Registered Nurse (APRN), as defined under R.I. Gen. Laws § 5-34-3; who functions in the population focus of psychiatric/mental health as defined under R.I. Gen. Laws § 5-34-3(12)(vi); and whose scope of practice is defined under R.I. Gen. Laws § 5-34-3(1), § 5-34-3(2), and § 5-34-3(15)/

c. The medical director or chief medical officer, regardless of place of residence, shall maintain a physical presence on-site at the CCBHC location(s) to ensure the quality of the medical/behavioral component of care.

d. The CCBHC staffing plan for each of the required children's services shall meet the requirements of both federal certification standards for CCBHCs and Rhode Island-specific standards as delineated in this

Part. The staffing plan shall be informed by the community needs assessment and statewide needs assessment.

3. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of children receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria.

4. The Chief Executive Officer (CEO), or equivalent, of the CCBHC shall maintain a fully staffed management team as appropriate for the size and needs of the clinic and children served, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical Director) may be held by the same person.

5. The CCBHC staff shall include a medically trained behavioral health provider, either employed by the CCBHC or engaged through a formal agreement, who can independently prescribe and manage medications for children pursuant to state law.

6. The CCBHC shall include employed or contracted staff with expertise in addressing trauma and promoting healthy development and well-being for children with behavioral health needs and conditions, including serious emotional disturbance (SED), and intellectual development disabilities.

7. Staff must hold the necessary credentials for their roles and work under the supervision of appropriately licensed professionals to effectively support children with acute needs. The provider ensures that all staff delivering services are provided regularly scheduled weekly supervision by an independently licensed, master's level clinician or above.

8. Staffing must reflect the cultural and linguistic diversity of the community.

J. Training specific to CCBHCs

1. CCBHCs, as well as DCOs, are subject to general staff competency and training requirements, found herein at § 8.2.24.

2. CCBHCs shall be subject to the following additional staff competency and training requirements:

a. The CCBHC shall develop, implement, and maintain a training plan for employed and contracted staff serving children. The initial training plan

shall be submitted to the department for review and approval with the CCBHC licensing application.

b. The CCBHC shall maintain a comprehensive training plan for all employed and contracted staff who have direct contact with children receiving services or their families.

c. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on the following topics

(1) Evidence-based practices for children and families.

(2) Cultural competency, as defined in § 8.5.2(K) herein.

(3) Child and family-guided, family-centered, and recovery-oriented planning and service delivery.

(4) Trauma-informed care.

(5) The clinic's policies and procedures for continuity of operations and disaster response as are relevant to child and family services.

(6) The clinic's policies and procedures for integration and coordination with primary care for children.

(7) Care for children's co-occurring mental health and substance use disorders.

d. In addition, at orientation and annually thereafter, the CCBHC must provide training to staff serving children and families on:

(1) Risk assessment

(2) Crisis de-escalation

(3) Suicide and overdose prevention and response

(4) Roles of family members and peer support staff

e. Trainings may be delivered online.

f. Each CCBHC shall ensure that all staff working with children, including direct care, clinical, operations, and administrative personnel, complete Community First Responder Naloxone Training.

g. The CCBHC shall establish criteria and a process for assessing the skills and competence of all employed and contract staff who have direct contact with children seeking or receiving CCBHC services and, as necessary, shall provide in-service training and education programs to address any identified deficiencies.

(1) The CCBHCs shall provide ongoing coaching and supervision to ensure initial and ongoing compliance with and fidelity to evidence-based, evidence-informed, and promising practices for children.

(2) Employees and contracted staff providing training shall be qualified to do so as evidenced by their education, training, and experience.

h. The CCBHC shall maintain written documentation of any in-service training provided for the duration of each employment or contract term. The CCBHC shall document that each employee and/or contracted staff member has completed the requisite trainings.

i. Upon request from the Department, CCBHCs shall provide written documentation that all training requirements, including those related to federal and state cultural competence and linguistic competence training, have been met by the CCBHC for staff working with children and families.

K. Language access and cultural and linguistic competency

1. Service provision shall advance health equity and strive to eliminate disparities for children.

2. CCBHCs shall take reasonable steps to provide meaningful access to children's services, such as language assistance, for those with Limited English Proficiency (LEP) or language-based disabilities.

a. Interpretation/translation service(s) shall be readily available to children and legal guardians. Interpretation/translation services shall be appropriate for the size and needs of the CCBHC population that has Limited English Proficiency (LEP) and, as appropriate, include but not be limited to bilingual providers, onsite interpreters, videos in the language of children and families served, or a language-competent telephone line.

b. To the extent interpreters are used, such translation service providers shall be trained to function in a medical and, preferably, a behavioral health setting. Any CCBHC or DCO that engages the services of an

interpreter, whether bilingual or sign-language, shall require the interpreter to provide documentation of completed training to provide interpreter services in a medical, and preferably in a behavioral health, setting.

3. CCBHCs shall provide meaningful access to interpreter services for children who are hearing impaired, as well as to the legal guardian to effectuate meaningful participation in the child's treatment. Such services may be in-person or through a formal agreement with an independent remote service provider, to be determined by the size and needs of the CCBHC's population. All auxiliary aids and services, including but not limited to sign language interpreters and teletypewriter (TTY) lines, shall be available and shall comply with the Americans with Disabilities Act (ADA).

4. Auxiliary aids and services shall be available and responsive to the needs of children receiving services with physical, cognitive, or developmental disabilities including but not limited to sign language interpreters and teletypewriter (TTY) lines and shall comply with the ADA.

5. Children shall not be asked to translate or interpret for their parents/guardians. Additionally, family members or other informal supports shall not serve as translators or interpreters in treatment settings.

6. CCBHC policies shall have explicit provisions for ensuring that all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include but are not limited to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 C.F.R. Part 2; the Confidentiality of Health Care Information Act, R.I. Gen Laws § 5-37.3-1, et seq.; the Mental Health Law, R.I. Gen. Laws §§ 40.1-5; and other relevant federal and state laws, including those that address patient privacy requirements specific to the care of minors.

7. Documents or information vital to the ability of a child receiving services to access CCBHC services, including but not limited to registration forms, sliding scale fee discount schedules, after-hours coverage, and signage shall be available online and in paper format in languages commonly spoken within the community served, as determined by the community needs assessment, consistent with literacy levels and the need for alternative formats. Such materials shall be provided in a timely manner at intake and throughout the time a child is served by the CCBHC.

8. CCBHCs and DCOs shall post notices of the availability of documents or information vital to the ability of a child receiving services and the legal guardian, as required by law, to access CCBHC services in languages commonly spoken within the community served, consistent with literacy levels

and availability of alternative formats. Such notices shall be posted in prominent locations where services are provided, including but not limited to intake areas, waiting areas, and examination rooms and on the CCBHC's and DCO's public-facing platforms.

L. Availability and accessibility of services

1. General Requirements: In addition to the CBHO requirements listed herein, CCBHCs shall be subject to following minimum requirements:

a. The CCBHC directly, or through a Designated Collaborating Organization (DCO), shall provide outpatient behavioral health care, including psychopharmacological treatment, using evidence-based best practices, as specified or required by the Department, for children and families.

b. Any child and their legal guardian who seeks services from a CCBHC shall be free to select and receive services from a CCBHC of their choice and a DCO that contracts or has a formal agreement with that CCBHC. Children are not restricted to the CCBHC designated for their community of residence or its affiliated DCO(s) or any provider with which the CCBHC or DCO has a Care Coordination Agreement; however, the services sought by the child may be limited to the CCBHC's service area.

c. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services, either directly or through DCO agreement, in the CCBHC service area.

d. Each CCBHC shall be open for service provision a minimum of fifty (50) hours per week.

e. Each CCBHC shall have open access hours for children:

(1) Open access means the availability for children's walk-ins and same day appointments.

(2) CCBHCs shall have designated hours available for children at least three (3) days per week for open access services.

(3) CCBHCs shall educate all staff about the availability of open access for children.

f. No child who seeks services from a CCBHC shall be denied services due to race, age, sexual orientation or gender designation, ability to pay, place of residence, homelessness, the lack of a permanent

address, involvement in the criminal justice system, or any co-occurring and/or dually diagnosed behavioral health or intellectual developmental disability.

g. Any fees or payments required by the CCBHC for CCBHC services shall be reduced or waived to enable the CCBHC to fulfill its obligation to provide services despite a child or legal guardian's inability to pay for such services.

(1) The CCBHC shall employ a standard means test and implement a sliding fee scale.

(2) The CCBHC shall publish sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to federal certifications standards and state-specific requirements as delineated in these regulations. Such fee schedules shall be included on the CCBHC website, posted in the CCBHC waiting area(s), and be readily accessible to children receiving services and their families. The sliding fee discount schedule shall be communicated in languages and formats appropriate for children seeking services who have Limited English Proficiency (LEP), literacy barriers, or disabilities.

h. Services shall be provided that are appropriate for the developmental stage of the child receiving services. These services shall be provided by staff with specific training in treating the segment of the population being served. CCBHCs shall utilize evidence-based strategies including but not limited to measurement-based care (MBC) to improve service outcomes.

(1) When treating children and adolescents, CCBHCs shall provide evidence-based or evidence-informed services that are developmentally appropriate, child and family-guided, and family-centered.

(2) When treating children dually diagnosed with a behavioral health disorder and intellectual developmental disabilities, level of functioning shall be considered, and appropriate evidence-based or evidence-informed treatments shall be provided.

i. The CCBHC shall adopt and implement a Referral Policy and Procedure related to children's referrals to providers that diagnose and treat in clinical areas that are outside the CCBHC's area of expertise for children. The policy and procedure shall include a requirement that staff shall document in the child's record any referral made and whether the child began treatment with the provider.

j. If a child requires specialized services beyond the scope of services provided by a CCBHC, a referral shall be made to an appropriate DCO. If the DCO is not able to provide the specialized service for which the child was referred, the DCO shall inform the referring CCBHC that shall refer the child to another provider who is qualified to provide the specialized service. The referring CCBHC shall track receipt of services from the provider to whom the child was referred pursuant to the CCBHC's Referral Policy and Procedure.

k. The CCBHC shall coordinate care that is consistent with the preferences of the child receiving services and their care needs.

l. CCBHCs shall provide children receiving services and their legal guardian, as required by law, access to the CCBHC's grievance procedures and the right to grieve any decision, whether the services are being provided directly by the CCBHC or the services are being provided by a DCO with whom the CCBHC has a formal written agreement, contract, or Memorandum of Understanding to provide such service(s).

m. The CCBHC shall participate in the SAMHSA Behavioral Health Treatment Locator.

n. The CCBHC shall ensure that services are provided during times that facilitate accessibility and meet the needs of the children and families served by the CCBHC, including evening and weekend hours.

o. The CCBHC shall provide services at locations that ensure accessibility and meet the needs of the children and families served, such as settings in the community, including but not limited to schools, social service agencies, partner organizations, community centers, and, as appropriate and feasible, wherever children receiving services are located.

p. The CCBHC shall provide transportation or transportation vouchers for children receiving services and their legal guardians to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the child and family-centered plan of care.

q. Consistent with the preferences of the child receiving services and to facilitate access to all required services, the CCBHC shall use telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, or other technologies, to the extent possible and pursuant to state and federal laws and regulations. The CCBHC, however, is not required to provide continuous services,

including telehealth, to children who live outside of the CCBHC service area.

r. Informed by the community needs assessment, the CCBHC shall conduct outreach, engagement, and retention activities to support inclusion and access for underserved children and families.

(1) The CCBHC shall have staff dedicated to outreach and engagement for children who shall not carry a client caseload in addition to outreach and engagement responsibilities.

(2) The CCBHC shall establish and implement policies and/or procedures regarding outreach and engagement activities to assist children and families in accessing appropriate services.

(3) The CCBHC shall document, track, and report on outreach and engagement activities to children and populations not currently attributed to a CCBHC.

M. Triage

1. All children newly receiving services, whether requesting or being referred for behavioral health services at the CCBHC, shall, at the time of first contact, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically.

2. The preliminary triage, including risk assessment, shall be followed by:

a. An initial evaluation.

b. A comprehensive assessment, consistent with the requirements as specified in federal CCBHC Certification Standards and herein.

3. If the triage identifies a crisis need, appropriate action shall be taken immediately, including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient or inpatient follow-up.

4. If triage identifies an urgent need, clinical services shall be provided, including an initial evaluation within one (1) business day of the time the request is made.

5. For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through the use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation with the child and legal guardian is preferred.

6. If the initial evaluation is conducted telephonically, once the emergency is resolved, the child receiving services shall be seen in person at the next subsequent encounter and the initial evaluation reviewed.

7. If the triage identifies routine needs, services will be provided, and the initial evaluation completed within ten (10) days.

8. Notwithstanding the option to conduct preliminary triage, including initial risk assessment or initial evaluation through the use of telehealth/telemedicine or other remote technologies in response to an emergency/crisis or urgent need, applications for emergency certification shall be based upon an in-person examination of the child by the applicant, pursuant to the Mental Health Law, R.I. Gen. Laws §§ 40.1-5.

9. If a child already receiving services from a CCBHC or DCO presents with an emergency/crisis need, appropriate action shall be taken immediately based on the needs of the child receiving services, including immediate crisis response if necessary.

10. If a child already receiving services from a CCBHC or DCO presents with an urgent, non-emergency need, clinical services shall be provided within one (1) business day of the time the request is made or at a later time if that is the preference of the child receiving services.

11. Children who are already receiving services from a CCBHC or DCO who are seeking routine outpatient clinical services shall be provided with an appointment within ten (10) days of the request for an appointment, unless federal laws or regulations or applicable accreditation standards are more stringent.

N. Care coordination

1. General requirements of care coordination

a. Services must be delivered by a multidisciplinary team using a collaborative, interdisciplinary approach.

b. For CCBHCs, care coordination includes both behavioral and physical health care, regardless of whether the care and services are provided directly by the CCBHC, through a formal agreement with a Designated Collaborating Organization (DCO), or through referral or other affiliation with care providers and facilities outside the CCBHC. Care coordination is regarded as an activity rather than a service.

c. The CCBHC shall coordinate care across the spectrum of health services, including but not limited to access to high-quality acute and

chronic physical health and behavioral health care, as well as social services, housing, education, and employment/vocational supports, as necessary to facilitate wellness and recovery of the whole child and family. The CCBHC shall also coordinate with other systems to meet the needs of the children and families served, including criminal and juvenile justice and child welfare.

d. The CCBHC shall obtain all necessary signed releases of information prior to sharing protected healthcare information that is subject to the privacy and confidentiality protections of HIPAA, 42 C.F.R. Part 2, and other federal and state laws and regulations.

e. The CCBHC shall develop a crisis plan with each child receiving services and the legal guardian, as required by law. At a minimum the crisis plan shall include counseling about the use of 9-8-8, mobile crisis, and mobile response and stabilization services should a crisis arise when providers are not in their office.

f. To the extent that state law allows, the CCBHC shall consult the state's Prescription Drug Monitoring Program (PDMP) prior to prescribing controlled substances. The PDMP shall also be consulted during the comprehensive assessment. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care and in compliance with federal and state law and regulations.

g. CCBHCs shall assist children receiving services and their families to access benefits, including Medicaid, and to enroll in programs or supports that may benefit them.

h. CCBHCs shall track Medicaid hospital and emergency department intakes and discharges and shall make and document reasonable efforts to track hospital and emergency department intakes and discharges for all children served, including but not limited to non-Medicaid children.

i. CCBHCs shall track when children receiving their services are admitted to inpatient facilities, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity that has been confirmed in writing.

2. Partnerships and Required Care Coordination for Children and Families

a. The Department requires CCBHCs to maintain Care Coordination Agreements with:

(1) Service area hospital(s) / emergency department(s).

(2) Service area urgent care facilities.

(3) Federally Qualified Health Centers (FQHCs).

(4) Service area primary care providers.

(5) Butler Hospital.

(6) Bradley Hospital.

(7) Hasbro Children's Hospital.

(8) Service area police/emergency medical services (EMS).

(10) BH Link.

(11) 9-8-8 Suicide and Crisis Lifeline.

(12) Catchment area Family Care Community Partnerships (FCCP) providers.

(13) Accountable Entities (AE).

(14) Rhode Island Training School.

(15) Court(s) located in the CCBHC designated service area.

(16) Providers specializing in supports and services for children with intellectual developmental disabilities.

b. For Care Coordination Agreements with inpatient acute care hospitals and their associated emergency departments, hospital outpatient clinics, and urgent care centers, the CCBHC shall make and document reasonable attempts to contact all children receiving CCBHC services or the legal guardian, as required by law, within twenty-four (24) hours of discharge.

(1) For all children receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the Care Coordination Agreement between these facilities and the CCBHC shall include a requirement to coordinate consent and follow-up services with the child and/or guardian, as required by law, receiving CCBHC services within twenty-four (24) hours of

discharge and shall continue until the child is successfully referred to services or is assessed to be no longer at risk.

c. CCBHCs shall establish policies and procedures that promote and describe the coordination of care with each child's Primary Care Provider (PCP). At the time of the initial assessment, the CCBHC shall inquire whether the child has a PCP and shall assist children who do not have a PCP to acquire one.

d. CCBHCs shall develop and document partnerships with the following organizations that operate within the service area:

(1) Local education agencies and schools.

(2) Child welfare agencies.

(3) Juvenile and criminal justice agencies, facilities, and entities (including recovery, mental health, and other specialty courts).

(4) Community organizations serving children and families.

(5) Indian Health Service regional treatment centers.

(6) State licensed, nationally accredited child placing agencies for children in the Department's care.

e. CCBHCs shall make reasonable attempts to establish and document partnerships with the following types of entities consistent with the needs and preferences of the children and families served and the needs identified in the community needs assessment. Examples of such partnerships include but are not limited to the following:

(1) Specialty providers, including those who prescribe medications for the treatment of opioid and alcohol use disorders.

(2) Suicide and crisis hotlines and warmlines.

(3) Indian Health Service or other tribal programs.

(4) Homeless shelters.

(5) Housing agencies.

(6) Employment services systems.

(7) Disability Resource Centers.

(8) The Rhode Island Department of Health.

(9) Substance use prevention and harm reduction programs.

(10) Criminal and juvenile justice agencies and organizations, including law enforcement, courts, prisons, detention centers, and other incarceration facilities.

(11) Legal aid services.

(12) Immigrant and refugee services.

(13) Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs.

f. CCBHCs shall obtain all necessary signed releases of information prior to sharing protected healthcare information with community partners where information is subject to the privacy and confidentiality protections of the Health Insurance Portability and Accountability Act (HIPAA) (2025), Health Information Technology Economic and Clinical Health (HITECH) (2009), 42 C.F.R. Part 2, and other applicable federal and state laws and regulations.

g. CCBHC service arrangements shall address the needs of tribal children and their families as identified in the Community Needs Assessment.

O. Plan of Care Development – Additional Requirements for CCBHCs

1. Notwithstanding additional requirements under this regulation in § 8.4.4 herein, the plan of care shall address the child's prevention, medical, and behavioral health needs, including the following:

a. Wellness and recovery planning and supports.

b. Safety planning.

c. Required services and supports, including but not limited to care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, and accommodations to ensure culturally and linguistically competent services.

d. Community inclusion and support, including but not limited to housing and social supports.

e. Involvement of family and other supports.

2. Notwithstanding additional requirements under this regulation, the CCBHC shall designate an interdisciplinary treatment team, including the child receiving services and legal guardian, as required by law, that is responsible for directing, coordinating, and managing care and services. The interdisciplinary treatment team shall include the child's family, to the extent the child receiving services and their legal guardian desire their involvement and it is legally required, notwithstanding the expressed desires of the child receiving treatment.

3. The interdisciplinary team shall coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the child receiving services. These services shall include, as appropriate and desired by the child receiving service and the legal guardian(s), traditional approaches to care for children who are native or indigenous or from other cultural and ethnic groups.

P. CCBHC Scope of Services for Children and Youth – General Requirements

1. The CCBHC shall provide child and family-centered care that is responsive to the race, ethnicity, sexual orientation, and gender identity of the child receiving services and shall include care that recognizes the cultural and other needs of the child. Services must be developmentally appropriate, inclusive, and accessible, ensuring equitable access and outcomes across all populations.

2. CCBHCs shall ensure access to evidence-based practices and maintain comprehensive, culturally competent assessment standards. All assessments must be standardized, validated, and developmentally appropriate, and must account for cultural, linguistic, literacy, and disability-related needs. Assessments may be conducted via telehealth, where permitted by law. Where specialized services, such as neuropsychological or developmental evaluations, are required and beyond the CCBHC's scope, timely referrals to qualified providers must be made.

3. CCBHCs shall be required to administer the following screenings utilizing standardized measurements upon Intake and at regular intervals throughout the course of a child's treatment:

a. Depression.

b. Suicide risk.

c. Self-harm risk.

d. Alcohol and substance use

(1) If screening identifies problematic alcohol or other substance use, the CCBHC shall conduct a brief intervention and the receiving services shall be provided a full assessment and treatment, if appropriate within the level of care of the CCBHC, or shall be referred to a more appropriate level of care.

(2) If the screening identifies immediate threats to the safety of the person receiving services, the CCBHC shall take appropriate action pursuant to this Part.

e. Abuse / neglect / exploitation / mistreatment.

f. Traumatic Brain Injury (TBI): Each CCBHC shall provide TBI screening using the Online Brain Injury Screening and Support System (OBISSS) if there has been no TBI screening within the twelve (12) months prior to the child receiving services from the CCBHC.

4. CCBHCs must coordinate care with a child's primary care provider, other behavioral health providers, state agencies, and family members, ensuring integrated and effective service delivery.

5. Children and families have the right to choose their providers, whether within the CCBHC, its DCOs, or from external providers, supporting individualized care planning and service autonomy.

6. CCBHCs must develop and implement policies and procedures describing, whether delivered directly or through a DCO agreement, that the CCBHC shall ensure that service enhancements are implemented when necessary.

7. Required Services: CCBHCs must ensure access to the following required services, either directly or through a DCO, as specified under PAMA:

a. 24/7 Crisis Services.

b. Outpatient Mental Health and Substance Use Services.

c. Child and Family-Centered Treatment Planning.

d. Peer Family Support and Counselor Services.

e. Targeted Case Management.

f. Outpatient Primary Care Screening and Monitoring.

g. Psychiatric Rehabilitation Services.

h. Screening, assessment and diagnosis.

Q. CCBHC General Outpatient (GOP) Services

1. Children up to age 18 are eligible for services to address both short-term and ongoing emotional, behavioral, developmental, and mental health needs.

2. All GOP services shall meet these requirements:

a. Services may be delivered in office, home, or community-based settings, depending on the child's needs and plan of care.

b. The provider shall maintain a clinician-to-client ratio not to exceed one (1) full-time clinician per twenty-five (25) active weekly cases to ensure quality of care.

c. No functional assessment is required for eligibility.

R. CCBHC High Acuity Services

1. High Acuity Services are intended to stabilize children and youth at home and in the community who are at risk of being admitted to more intensive programs (e.g., inpatient hospital programs, residential treatment centers) or to support children and youth transitioning from such facilities back into the community. These services are designed with an emphasis on family involvement, empowering caregivers, and addressing key issues related to the child's behavioral health challenges. The long-term aim is to prepare the child for a transition to less intensive, longer-term outpatient treatment to achieve sustainable positive outcomes.

2. Children may qualify for High Acuity Services if they:

a. Are under the age of 18.

b. Meet at least one of the following criteria:

(1) Child has a history of psychiatric hospitalization, suicide attempts, self-harm, or suicidal or homicidal ideation.

(2) Child has had emergency department visits indicating risk of hospitalization or out-of-home placement.

(3) Child is transitioning from a higher level of care, such as inpatient or residential settings.

(4) Child has experienced acute crises significantly affecting their functioning.

(5) Child has co-occurring moderate to severe substance use disorders.

(6) Child has experienced trauma.

(7) Child is involved with multiple systems (e.g., child welfare, juvenile justice, special education).

(8) Child is currently unhoused or has experienced housing instability.

(9) Child has a qualifying DSM diagnosis or other condition of treatment, as defined by the Department, that is related to impairments in functioning in multiple life domains.

(10) A functional assessment score that demonstrates the need for High Acuity services based on criteria established and reviewed annually by the Department.

(11) Any additional criteria identified by the Department.

c. Request for exceptions to eligibility criteria may be made at any time in writing to the Department and can be approved for up to ninety (90) days for attribution to the children's high acuity population.

d. A child receiving High Acuity Services must be re-evaluated every ninety (90) days to determine if this level of service intensity continues to be necessary. An updated functional assessment is required.

e. High Acuity services shall be delivered at a frequency higher than standard outpatient care, with a minimum number of service hours per month per child, to be determined by the Department.

(1) The total number of service hours may vary based on the specific program model and the individualized needs of the child, though services are generally expected to occur two to three times per week.

(2) Programs must offer flexible scheduling, including evening and weekend hours, to accommodate family needs.

(3) The duration of treatment shall be based on clinical need and the individualized plan of care, with an average episode of care typically lasting twelve (12) to sixteen (16) weeks.

3. The recommended staffing ratio is one clinician per eight (8) to ten (10) children, with flexibility for specific treatment models.

4. Staff in high acuity programs must have at least one (1) year of direct experience working with the target population.

a. Waiver requests per § 8.2.11 herein may be submitted to the Department when staff members do not meet this requirement.

S. CCBHC Crisis Services

1. As mentioned in § 8.5.1 herein, the CCBHC is required to be licensed and be subject to the requirements of the Mental Health Emergency Service Interventions for Children, Youth and Families Regulations for Licensure under 214-RICR-40-00-6. The CCBHC shall provide behavioral health crisis response services for children directly or through a DCO agreement with providers licensed as an Emergency Services provider. Crisis response services shall be available and accessible twenty-four (24) hours a day, seven (7) days a week.

2. In addition to the requirements of the Mental Health Emergency Service Interventions for Children, Youth and Families Regulations for Licensure 214-RICR-40-00-6, the CCBHC shall provide crisis receiving/stabilization that includes, at a minimum, urgent care/walk-in mental health and substance use disorder services.

a. Urgent care/walk-in services shall identify a child's immediate needs, de-escalate any crisis, and connect the child to a safe and least-restrictive setting for ongoing care, including care provided by the CCBHC.

b. Walk-in hours shall include evening hours, the availability of which are publicly posted.

c. Urgent care/walk-in services shall be available to children of any level of acuity. However, the Organization need not manage care for the highest acuity children in this ambulatory setting.

3. Crisis stabilization services shall be available twenty-four (24) hours per day, seven (7) days a week. To the extent possible, the CCBHC shall provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care (2020).

4. Services provided shall include suicide prevention and intervention:

    a. The CCBHC or its DCO crisis care provider shall offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed.

    b. The CCBHC shall have an established protocol specifying the role of law enforcement and Community Mental Health Liaisons during the provision of crisis services.

    c. The CCBHC shall specifically focus on the application of trauma-informed approaches during crises.

    d. The CCBHC shall provide information regarding harm reduction and available statewide resources

T. CCBHC Targeted Case Management

1. The CCBHC is responsible for providing directly, or through a DCO, targeted case management services.

2. Targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC.

3. Targeted case management services shall assist children receiving services in achieving well-being and healthy development and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports.

4. Targeted case management shall include supports for children deemed at high risk of suicide or overdose, particularly during times of transitions (e.g., from a residential treatment, hospital emergency department, or psychiatric hospitalization) or during other critical periods (e.g., during episodes of being unhoused or transitions to the community from jails or prisons).

5. Targeted case management shall be used for children with complex or serious mental health or substance use conditions and for children who have a short-term need for support in a critical period, such as an acute episode or care transition.

6. Each CCBHC is required to provide, either directly or via a DCO, ACT services to transition aged youth.

U. CCBHC Psychiatric Rehabilitation

1. The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for behavioral health disorders.

2. Rehabilitative services shall include services and recovery support that help children develop skills and functioning to facilitate proper development and functioning within a family and community; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of goals as part of a transition to adulthood.

3. Psychiatric rehabilitation services must include the following supports, programming, and services for children relative to the following:

   a. Employment: supports for children to obtain and maintain competitive, integrated employment, as appropriate.

   b. Education: supports for participation in supported education and vocational services.

   c. Social: supports to assist children to achieve social inclusion and community connectedness.

   d. Wellness: supports in medication education, self-management, and/or child and family/caregiver psychoeducation.

   e. Housing: Support services to help families with children secure and sustainable safe and stable housing.

4. Psychiatric rehabilitation services for children, youth, and their families may include the following supports:

   a. Training in personal care skills.

   b. Community integration services.

   c. Cognitive remediation.

   d. Facilitated engagement in substance use disorder mutual help groups and community supports.

   e. Assistance for navigating healthcare systems.

f. Other recovery support services, including illness management and recovery, financial management, and dietary and wellness education.

g. Peer supports.

V. CCBHC Continuous Quality Improvement (CQI) Plan

1. In order to maintain a continuous focus on quality improvement, the CCBHC shall develop, implement, and maintain an effective CCBHC-wide continuous quality improvement (CQI) plan for children's services.

2. The CCBHC shall establish a critical review process to review children's CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services.

3. The CQI plan shall be data-driven and the CCBHC shall use quantitative and qualitative children's data to guide CQI activities. At a minimum, the plan shall address the data resulting from the CCBHC-collected and, as applicable for the § 223 Demonstration, state-collected, quality measures that may be required as part of the Demonstration.

4. The plan shall identify how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve children's outcomes for populations facing health disparities.

5. The CQI plan shall focus on indicators related to improved behavioral and physical health outcomes for children and shall identify actions to be taken to demonstrate improvement in CCBHC performance.

6. The CQI plan shall identify improved patterns of care delivery, including but not limited to reductions in emergency department use, rehospitalization, and repeated crisis episodes for children.

7. The Medical Director shall participate in the development of the section of the CQI plan that applies to the quality of the medical components of care for children, including coordination and integration with primary care.

8. The CQI plan shall address how the CCBHC will review known significant events, including but not limited to the following:

a. Deaths by suicide or suicide attempts of children receiving CCBHC services.

b. Fatal and non-fatal overdoses experienced by children receiving CCBHC services.

c. All-cause mortality among children receiving CCBHC services.

d. Thirty (30) day hospital readmissions for psychiatric or substance use reasons of children receiving CCBHC services.

e. Abuse of children receiving services by CCBHC staff.

f. Abuse of CCBHC staff by children receiving CCBHC services and family members.

g. Urgent appointments not scheduled within twenty-four (24) hours.

h. Such other events as the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.

9. The CCBHC shall retain all records of the data collected in support of the CQI plan in a centralized location for a minimum of ten (10) years unless otherwise required by state and/or federal laws and/or regulations.

W. Data Collection, Reporting, and Tracking

1. Data collection, reporting, and tracking shall comply with the requirements for all licensed Children's Behavioral Health Organizations, pursuant to §8.3.1 herein.

2. Each CCBHC shall collect, maintain, and report to the Department data to demonstrate compliance with the following CCBHC licensing and/or certification standards:

a. Provision of clinical services for children with urgent needs within one (1) business day.

b. Provision of clinical services for children with routine needs.

c. A comprehensive assessment is required for all children receiving CCBHC services and must be completed within thirty (30) days of the initial intake.

d. CCBHCs shall make and document reasonable attempts to contact all children, and their legal guardian, receiving CCBHC services who are discharged from a hospital emergency department or inpatient unit within twenty-four (24) hours of discharge.

e. The CCBHC shall deliver the federally required services and any additional Rhode Island required services, directly or through formal

arrangements with a DCO, but shall directly provide services for at least 51% of all CCBHC encounters (excluding crisis services).

f. The CQI plan that, at a minimum, focuses on deaths by suicide or attempts; fatal and non-fatal overdose; all-cause mortality; thirty (30) day hospital readmission for mental health or addiction; and others as determined by the State.

g. Measure and track calls made from call center to CCBHC or DCO crisis care provider.

h. The plan of care for children reviewed at a minimum of every ninety (90) days.

i. Measure the volume and availability of services through same-day access options.

j. CCBHC shall assist children receiving services with making external appointments and tracking participation in services.

k. Reports of incidents of abuse by CCBHC staff of children receiving services

l. Reports of abuse of CCBHC staff by children receiving CCBHC services and family members.

m. Number of urgent appointments not scheduled within one (1) day from the time of the request.

3. CCBHCs shall comply with the reporting requirements according to the schedule and in the manner required by the Department.

4. Each CCBHC shall submit a complete and updated CCBHC staffing template at regular intervals to be determined by the Department. This reporting requirement will serve to demonstrate compliance with ongoing staffing levels as compared to state-approved staffing plans.

5. CCBHCs shall participate in the statewide Health Information Exchange (HIE) to facilitate data sharing, care coordination, and quality reporting for CCBHCs.

X. Continuity of Operations, Disaster Plan, and Insurance

1. The CCBHC shall maintain a continuity of operations/disaster plan. The plan shall ensure that the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster or

emergency occurs and/or services are disrupted. The CCBHC, to the extent feasible, shall identify alternative locations and methods to sustain children's service delivery and access to behavioral health medications for children during emergencies and disasters. The plan shall also address health information technology (IT) systems security/ransomware protection and backup, as well as access to IT systems, including health records, in case of disaster/emergency and/or disrupted services.

2. The CCBHC and CBHO-licensed DCOs shall comply with all requirements for CBHOs with respect to Emergency Management Plans and local fire ordinances.

3. If a DCO is not licensed by the Department as a CBHO, the DCO shall maintain a continuity of operations/disaster plan that is aligned with the plan of the CCBHC with which it has a formal agreement.

4. The CCBHC shall maintain liability/malpractice insurance adequate for the staffing and scope of children's services provided as required by federal Certification Standards and any additional requirements as delineated in these regulations. All CCBHCs and their affiliated DCOs shall comply with state insurance requirements.

Y. Infection Control

1. All CCBHCs are required to maintain an infection control plan and comply with all requirements for CCBHCs with respect to infection control.

2. The Infection Control policy will be made available to the Department upon application and at the Department's request.

3. Staff, employees, contractors, and volunteers shall be trained on the Organization's infection control plan annually.

Z. Health Information Systems

1. The CCBHC shall establish and maintain a health information technology (IT) system for children's services that includes but is not limited to electronic health records.

2. The CCBHC shall use technology that has been certified in accordance with current criteria under the Office of the National Coordinator (ONC) for Health IT's Health IT Certification Program for the required core set of certified health IT capabilities, as established by the federal CCBHC standards. These capabilities include but are not limited to:

a. Capturing health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).

b. At a minimum, supporting care coordination by sending and receiving summaries of care records.

c. Providing children receiving services and the legal guardian, as required by law, with timely electronic access to view, download, or transmit their health information or to access their health information via an application programming interface (API) using a personal health app of their choice.

d. Providing evidence-based clinical decision support.

e. Conducting electronic prescribing for children.

3. If, at the time of licensure, the applicant's IT system does not comply with the current criteria of the ONC Health IT Certification Programs, the applicant shall provide to the Department a detailed plan for implementing these requirements, including the creation and implementation of a personal health portal.

4. The CCBHC shall ensure that the DCOs with which it has a formal agreement comply with all federal and state laws and regulations for adults and minors pertaining to privacy and confidentiality requirements, including obtaining consent from children receiving services (and/or legal guardian, as required by law). Privacy and confidentiality requirements include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2; the Confidentiality of Health Care Information Act, R.I. Gen Laws § 5-37.3-1, et seq.; the Mental Health Law, R.I. Gen. Laws §§ 40.1-5; and other federal and state laws, including patient privacy requirements specific to the care of minors.

7.5.3 General Outpatient Services and Programs (GOP)

A. Outpatient level of care provides for treatment of conditions related to mild to moderate impairment.

1. Children appropriate for care at this level are generally able to sustain themselves between less frequent behavioral health appointments and to adhere to treatment recommendations with minimal intervention.

2. Treatment at this level of care is usually limited to one (1) to four (4) sessions per month but may be provided less frequently in accordance with the child's needs.

3. Outpatient care is typically site-based.

B. Organizations may provide a wide variety of programs and services but shall have the capacity to provide or arrange outpatient services to include:

1. Individual counseling and supports.

2. Group therapy.

3. Family counseling and supports.

4. GOP may also include:

a. Limited case management.

b. Psychoeducational services.

c. Peer supports.

5. GOPs must complete the following:

a. Services and the plan of care must be based upon a comprehensive assessment.

b. A comprehensive assessment shall be completed per § 8.4.3 herein.

c. A plan of care shall be completed per § 8.4.4 herein.

d. Assessment and monitoring occur throughout the duration of the treatment.

e. Discharge and aftercare planning.

6. For children with intellectual developmental disability needs, services may address social, communication, and self-care skills; school behaviors; and safety and compliance behaviors.

7. Organizations providing GOP shall develop and implement policies and procedures describing:

a. Intake, continuing care, and discharge criteria.

b. Use of evidence-based and best practices.

8. GOP must meet the general and supervisory staffing requirements defined in § 7.2.26(I) of this Part. Clinical services shall be delivered by adequately trained behavioral health professionals in accordance with applicable program specifications and scope of licensure.

9. GOP must meet documentation and treatment planning requirements as defined in § 7.2.26(H)(6)(k) and § 7.4.4 respectively.

7.5.4 Intensive Home-Based Services (IHBS)

A. Home-based and community-based behavioral health services shall support children and families to address complex mental health conditions or developmental disabilities that are adversely affecting a child in multiple life domains.

B. These programs and services may additionally address trauma, crises, or transitions.

1. Programs and services may include individual counseling, family therapy, group therapy, psychoeducation, skill-building, and care coordination.

2. For children with intellectual developmental disability needs, services may address social, communication, and self-care skills; school behaviors; and safety and compliance behaviors.

3. These services are customarily differentiated from traditional outpatient care by the greater number of hours of involvement, the multimodal approach, and the availability of specified crisis intervention services and supports.

C. Home-based and community-based behavioral health services shall aim to address child behavioral health needs to prevent hospitalization and out-of-home care or shorten the length of time a child spends out of a family setting. Children must be allowed to stabilize in a safe environment while connecting the child and family to the services they need, including individual, group, and family therapy; medication monitoring; and/or peer and youth support. IHBS services may also include wrap-around, case management, groups, and related interventions.

D. Home-based and community-based services shall aim to mitigate risk for children experiencing behavioral, developmental, mental health, and wellness challenges while allowing families to develop skills, resources, and natural supports; strengthen and stabilize children and families safely in their homes; promote pro-social behaviors; assist with positive child development; and reduce recidivism with juvenile justice-involved youth.

E. These services are delivered in a home setting and in the community to support the child's functioning in these settings.

F. Organizations offering these services must provide these services to children and families under the supervision of a licensed practitioner of the healing arts as defined in § 8.2.26(I) herein.

G. IHBS shall include:

1. A comprehensive assessment completed per § 8.4.3 herein.

2. A plan of care completed per § 8.4.4 herein.

3. Services and a plan of care that are based upon a comprehensive assessment and build on the strengths and address the needs identified in that assessment.

4. Assessment and monitoring that occurs throughout the duration of treatment.

5. Discharge and aftercare planning.

H. IHBS services must be delivered through a child-guided, family-driven, strengths-based model of care with applicable evidence-based or evidence-informed practices that support the safety and well-being of the child.

7.5.5 Intensive Outpatient Services (IOP)

A. IOP provides substantial clinical support for children who are either in transition from a higher level of care or at risk for admission to a higher level of care.

1. IOP services generally involve a minimum of nine (9) hours of services each week for a child, unless fewer hours are clinically documented as necessary, not to be less than six (6) hours per week.

2. IOP shall offer at least twenty (20) hours per week of clinical treatment and scheduled programming to address the treatment needs of the children served.

3. IOP shall operate a minimum of five (5) days per week.

4. Staff shall be available to schedule meetings and sessions at a variety of times to support involvement of family and other individuals for the child.

5. IOP can be provided in full-day increments of six (6) hours or half-day increments of three (3) hours.

B. Minimum requirements for IOP include but are not limited to the following:

1. Initial and ongoing assessments

a. An initial assessment shall be completed within seven (7) days of intake.

b. Ongoing updates to the assessment shall occur throughout the duration of IOP services.

2. Individualized treatment planning

a. Each child shall have an individualized child-guided, family-centered plan of care developed in collaboration with qualified staff. This plan must be regularly updated to reflect the child's progress and changing needs.

b. The initial individualized plan of care for each child served shall be developed within fourteen (14) days of intake to the program. If a child has been referred to by an inpatient-residential rehabilitation service, the referring Organization's child-guided plan of care may be utilized on a preliminary basis.

c. The child-guided plan shall be reviewed at least weekly during the child's enrollment in the program and revised as goals are accomplished or new treatment issues arise. Such reviews will be documented in the progress notes and on the plan of care.

3. Therapeutic interventions, including individual therapy, family therapy, and group therapy.

4. Care and case management.

5. Medication evaluation.

6. Medication management.

7. Progress monitoring.

8. Crisis prevention, planning, intervention, and emergency services.

9. Multi-disciplinary treatment team review.

10. Psychoeducational activities, skill development, and health literacy counseling.

11. Care coordination and referral for consultation, adjunctive or step-down services.

12. Discharge and aftercare planning.

C. IOP may offer other services in-house or through coordinated referrals such as the following:

1. Medication-assisted treatment.

2. Alcohol and drug monitoring.

3. Psychological or psychiatric assessments and services.

4. Peer support and recovery-oriented services.

5. Licensed childcare services.

6. Transportation.

7. Wellness programs (e.g., yoga or nutrition).

8. Medical services.

9. Vocational or educational services.

10. Occupational therapy.

11. Physical therapy.

12. Co-occurring enhanced groups.

D. Organizations providing IOP shall, at a minimum, develop and implement comprehensive policies and procedures describing the following:

1. Intake, continuing care, and discharge criteria.

2. Evidence-based practices offered as part of service provision.

3. Mechanisms for providing services in a frequency and intensity appropriate to a child's needs and treatment goals.

4. Organizations providing IOP shall maintain all appropriate concurrent state and/or federal licensure, certifications and accreditations, as required by law, regulation or policy.

E. Staffing

1. Direct care staffing for IOP shall not exceed one (1) staff to six (6) children.

2. Staffing shall include a multidisciplinary approach consisting of, at a minimum:

    a. Clinical or medical director/supervisor.

    b. Independently licensed practitioner or licensed practitioner of the healing arts as defined herein § 8.1.6.

    c. Physician, Nurse Practitioner, or other prescriber.

    d. Nurse/physician assistant or other qualified medical staff person.

3. Staffing may also include the following:

    a. Qualified mental health professional (QMHP).

    b. Certified peer recovery specialist.

    c. Occupational therapist.

    d. Psychiatric rehabilitation specialist.

    e. Case manager.

    f. Other professional supports deemed necessary to ensure the health and safety of all participants.

    g. Staffing shall reflect the cultural, gender, and linguistic needs of the community it serves. The program ensures access to qualified clinicians able to meet the cultural and linguistic needs of the children served within their local community.

4. Clinical supervision

    a. Clinical supervision of staff shall not exceed one (1) supervisor to every six (6) direct care staff members.

    b. All staff receive supervision consistent with credentialing criteria, licensing requirements, and state and federal laws.

7.5.6 Partial Hospitalization Programs (PHPs)

A. PHPs are intended to support children upon discharge from an inpatient hospital or residential program or to prevent a child from reaching such levels of care.

1. It is the need for intensive, active treatment of the child's condition, to maintain a functional level, and to prevent relapse or hospitalization that qualifies the child to receive PHP services.

2. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and other community supports) cannot provide the level of support necessary to maintain the child and to prevent hospitalization.

B. PHPs are structured to provide intensive care through active treatment that utilizes a combination of clinically recognized practices and services. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation.

1. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

2. Combined programs: Organizations may be licensed for different types of programs at the same site. However, such sites shall have separate programs and meet all the staffing and other requirements for the projected program capacity of each program.

C. Partial hospitalization reflects a high degree of structure and scheduling that includes the following:

1. A child-guided, family-centered plan of care, per § 7.4.4. Additionally, PHP plans of care shall adhere to the following requirements:

a. The plan is developed within the first three (3) days of service.

b. The plan is reviewed at least weekly and more often as necessary, updated as medically indicated, and signed by the treatment team members, including the child being served (and/or legal guardian, as required by law).

c. Progress on the plan of care is maintained and updated daily in case notes kept in the child’s medical record.

2. Coordination of services wrapped around the particular needs of the child.

3. Multidisciplinary team approach.

4. Program direction by a physician.

D. PHPs shall offer twenty (20) hours per week of clinical treatment and scheduled programming to address the treatment needs of the children served.

1. PHPs may operate seven (7) days per week and shall operate a minimum of five (5) full days a week.

2. Staff shall be available to schedule meetings and sessions at a variety of times to support involvement of family and other individuals for the child.

E. PHPs can be provided in full-day increments of six (6) hours or half-day increments of three (3) hours.

F. The following services shall be offered and provided to those children who demonstrate clinical necessity:

1. Clinical treatment and scheduled programming based on the child's clinical needs.

2. Coordination of care with other care providers and social services.

3. Clinical assessment once each program day.

4. Individual, group, or family therapy at least three (3) times per week.

5. Medication reconciliation and evaluation initiated within the first program day.

6. Activity therapies or psychoeducation, when determined to be clinically appropriate.

7. Recreation and social services.

8. Access to community-based rehabilitation/social services that can be used to help the child transition to the community.

9. Crisis planning, intervention, and follow-up.

G. PHPs shall also provide:

1. At least one (1) psychiatric evaluation and more frequent medication evaluations as needed (based on a one (1) to two (2) week average stay).

2. Face-to-face visits with a psychiatrist or other qualified practitioner (such as physician assistant, nurse practitioner, or advanced practice registered nurse under psychiatrist supervision) four (4) of five (5) days that the program is open.

3. Children's PHPs have a minimum of two (2) hours of assigned psychiatric time per week for every five (5) patients of program capacity to ensure adequate care and supervision for children in the PHP.

4. Screenings for childhood sexual exploitation, childhood trauma, self-harm, depression, suicide risk, abuse or neglect, and substance use.

H. Site Requirements

1. PHPs shall have accreditation by a Department-recognized national accreditation body.

2. PHPs shall operate as a separate, identifiable organizational unit with its own director or supervisor and staffing pattern.

   a. When the unit is a portion of a larger organizational structure, the director or supervisor of the unit is identified and responsibilities clearly defined.

   b. The organizational structure of the unit will be described in an organizational chart.

3. A written description of all services provided by the unit shall be on file and available to the Department. The Department shall be notified of any major change in the organizational structure or services.

I. Staffing

1. PHPs shall be staffed by an interdisciplinary team of credentialed mental health or addiction professionals, including counselors, psychologists, social workers, and board-certified physicians who are experienced in child-family specific competencies such as childhood trauma, sexual exploitation, substance use, child mental health, child and adolescent development, and child-specific diagnoses.

2. A physician shall be available for emergencies twenty-four (24) hours per day/seven (7) days per week.

3. Treatment team leader

   a. The treatment team leader is responsible for implementing and reviewing the individualized child-guided and family-driven plans, coordinating service delivery from other service providers, and reviewing progress notes and discharge summaries.

b. The treatment team leader assures that staff trained and experienced in using the modalities proposed in the child-guided and family-driven plan of care participate in its development, implementation, and review.

4. The following also applies to the treatment team composition for psychiatric PHP:

a. The program director must be a licensed mental health professional and have a minimum of two (2) years of post-graduate clinical experience; and

b. For children, the treatment team leader must be a physician or licensed psychologist.

J. Staff-to-child ratio

1. The staff/child ratio is determined based on the designed program capacity. However, a PHP shall have a minimum of one (1) full-time equivalent (FTE) clinical staff member for every six (6) children. For example, a program with a program capacity of thirty (30) requires five (5) FTE clinical staff members.

2. RN services are provided in an RN/client ratio sufficient to meet care needs, and other positions are staffed in adequate numbers to meet child and programming needs.

3. When there are changes in the program capacity, appropriate staffing changes shall be made as required. Staff must be of appropriate disciplines and include at least one (1) member, other than the program director, who is a licensed mental health professional or one (1) member who is a psychiatric nurse.

4. All clinical staff time devoted specifically to the PHP, including that of the program director and medical staff, will be included when calculating the patient to staff ratio. If a staff member devotes their time to another program or site, the time shall reflect the amount of actual time spent at the specified site. For example, if a full-time (40 hours per week) psychiatrist spends fifty percent (50%) of their time consulting at an outpatient site and fifty percent (50%) of their time at the PHP, twenty (20) hours or one-half (0.5) FTE are devoted to the PHP.

K. Staff qualifications: PHP staff shall be subject to staff qualification requirements as listed in § 7.2.26 – General Staffing Requirements and § 7.2.24 – Policies and Training.

7.5.7 Medication Management

A. If a CBHO does not provide medication evaluation and/or management services, the CBHO shall establish procedures to facilitate appropriate referrals for this service.

B. CBHOs providing medication evaluation and/or management services shall establish and implement policies and procedures that guide the safe and effective inclusion of medication evaluation and/or management within the Organization's service array. These policies and procedures, at a minimum, shall address the following:

1. Ordering, prescribing, and documenting medications according to law and regulation.

2. Process and documentation of informed consent and assent from minor, when appropriate.

3. Storage, control and distribution of all medications, including samples.

4. Distribution of medications to children in programs, at home visits, on therapeutic outings, and at discharge.

5. Process for prevention, identification, documentation, tracking, and reporting of medication variation, errors or misuse.

6. Process for documenting clinical recommendations and follow-up, especially regarding any medication changes, safety concerns, or side effects.

7. Protocols to follow when drug reactions and other emergencies related to the use of medications occur.

8. Process for ensuring appropriate referrals to medication management services when a child is discharged from a program and no longer able to receive medication management from the program.

9. Protocols for notifying child's primary physician regarding medication management.

C. A child who is receiving medication management services shall be seen at least quarterly by the prescribing physician or prescribing APRN, unless the physician or APRN documents that longer intervals are clinically appropriate.

D. For each appointment with the child served, the prescribing physician or prescribing APRN shall document the following in the child's record according to medical practice standards:

1. Clinical assessment including mental status examination, diagnoses, and any medically appropriate vital signs, lab results, or other relevant information.

2. All medications prescribed, renewed, or discontinued at the appointment.

3. The reason for prescribing, continuing, or discontinuing a medication.

4. Any changes in medications, the plan of care or monitoring recommendations.

5. The effectiveness of a continued medication.

6. Any signs or reports of side effects.

7. The treatment, if necessary, to address or prevent side effects.

8. Discussion with the child and guardian regarding risks and benefits of medications recommended or prescribed (including off-label use, if appropriate).

9. Review of all current and new medications to include confirmation that the combination of medications is reasonable and safe, including consideration of any drug interactions or underlying medical contraindications to medication.

10. Consideration of non-pharmacological interventions as part of a comprehensive plan of care including specific treatment recommendations when appropriate.

E. Verbal orders may be given, received, and transcribed only by qualified, licensed medical staff employed by the Organization.

1. Each verbal order shall be recorded in writing, dated and identified by the names and credentials of the individuals who gave it and received it.

2. The person who gave the verbal order must sign it the next day he or she is working at the Organization.

F. All medication orders shall be maintained in the child's treatment record.

G. Medications shall not be used for the convenience of a program, as a reward, or for the behavior control or punishment of children served.

H. The following information regarding medications is documented as provided to children, and families served, in a developmentally appropriate manner:

1. The rationale for the use of the medication, including intended benefits and potential risks and side effects associated with each medication.

2. Steps to be taken to minimize risks and side-effects.

3. A description of the clinical signs and symptoms that indicate a medication may need to be discontinued.

4. Alternatives to the use of medications, as appropriate.

5. Alternative medications, as appropriate.

6. The proper storage and securing of medications.

7. The availability of financial supports and resources to assist the children served with handling the costs associated with medications, when indicated.

I. Physicians and APRNs shall involve the child and family served in decisions related to use of medications.