Community Services Institute

Outpatient Mental Health Clinic

Policies and Procedures Manual
I. PROGRAM NARRATIVE

1.0 Program Description

Community Services Institute (CSI) is a free-standing, private mental health clinic dedicated to providing high quality mental health care to those individuals and families suffering from a diagnosable mental disorder. The Institute is capable of responding to a wide spectrum of mental health problems; however, the largest single focus of the program is the treatment of the hard-to-reach client who is guarded, and difficult to engage in traditional service models.

1.1 Program Philosophy

Community Services Institute is a community-based mental health clinic that strives to offer a wide spectrum of mental health services to the community at large. The Institute believes in providing a continuum of care that begins when a client, guardian, or other care and service provider recognizes the presence of a mental impairment.

CSI’s philosophy stresses providing the most appropriate mental health interventions for the medically necessary condition identified during the diagnostic phase of care. The Institute believes strongly in accurately assessing the initial complaints of clients and organizing a multidisciplinary intervention to provide the least restrictive, time-limited, and most expert mental health intervention possible, given the referral problem.

CSI’s philosophy further stresses the preservation of the family and the need to have families and individuals resolve crises rather than be placed in more intensive levels of care, such as residential programs, foster care, and hospitals. The Institute works to support and strengthen the family by utilizing the multidisciplinary resources at the clinic to quickly solve problems rather than to wait for a crisis to mount to a point where removal of any family member is necessary for safety sake.

The Institute strives to maintain a full spectrum of community-based mental health services available to the broadest cross-section of community members. The Institute employs the necessary clinical staff to respond to the full spectrum of mental health problems faced by adults, children and their caregivers ranging from psychiatric, developmental and behavioral issues, to the additional complications to these conditions which arise from the exposure to trauma and chronic poverty, and a host of other psychosocial stressors.

1.2 Program Objective

Community Services Institute is a licensed mental health clinic whose primary objective is to provide flexible, high quality, multi-disciplinary mental health services to clients within its community. Through its community-based practice and innovative treatment approach, the Institute implements its strong commitment to providing access and sustained engagement within all of its service areas.

Specifically, the Institute has the following primary objectives:
A) Facilitate rapid access to mental health assessment for those experiencing acute mental health disturbances.

B) Establish linkages within a larger community continuum that services clients from within the community, including problems referred by the Commonwealth of Massachusetts state agencies, courts, and foster parents, as well as from the general public within the various neighborhoods within the community.

C) Provide family preservation-oriented mental health services that stress problem resolution within the family rather than utilizing placement.

D) Provide medically supervised mental health interventions that allow for the creation of closely monitored Individualized Action Plan (IAP) s that quickly and efficiently identify the problem areas and work to bring solutions within measured and identified time frames.

E) Offer a full range of diagnostic services including psychiatric, psychological, educational, and other ancillary screening and assessment for clients suffering from a host of mental impairments.
II. SERVICES

2.0 Scope of Services

CSI will respond to the mental health problems identified at referral and through the Comprehensive Assessment and engagement process through the development of an Individualized Action Plan (IAP) that specifies the type of clinical services that will be provided at CSI. As indicated, CSI will refer to a more appropriate level of care within the scope of its programs, as well as, refer to an outside service provider as indicated by the assessment process. Individualized Action Plans (IAP) will be reviewed by a multi-disciplinary team and be updated regularly using case reviews and utilization reviews designating treatment junctures.

2.1 Client Registration

Requests for CSI services are recorded on a Therapy Request Form that becomes the first point of client tracking. The Therapy request form will document the date of referral, client name, phone number, and a brief description of their request. Within 7 days, the client will be contacted and provided with the information necessary to decide whether CSI services are appropriate and under what circumstances. If the client wishes to continue, the Full Intake Process begins.

2.2 Diagnostic Services

All CSI clients receive a thorough Comprehensive Assessment by the treating clinician(s). This procedure typically involves 1-3 interviews with the client and/or client guardian in order to obtain comprehensive background information. This includes precipitating events, the nature of the problem, the ongoing active stressors, a family history, medical history, drug history, past placements, active strengths, and work or school history. Standardized assessment tools, e.g. CANS and SOS-10, as well as, a host of other standardized psychometric measures will be utilized as indicated by regulations and client need.

This Comprehensive Assessment results in the development of an Individualized Action Plan (IAP) which is documented in the client record. These documents are monitored for quality and reviewed by the Utilization Review Team, and Multi-disciplinary team as well as the treating clinician’s primary clinical supervisor.

If the event that further information is needed to complete the diagnostic workup and this information is not obtainable through the use of resources within CSI, a referral for outside evaluations is made by the treating clinician.

2.3 Psychological Testing
Psychological testing is available to all clients and is utilized for the following objectives focusing primarily on (a) helping determine an appropriate Individualized Action Plan (IAP) (b) assessing neuropsychological and neurodevelopmental factors, (c) evaluating learning problems and assessing overall levels of intelligence, (d) assessing the impact of trauma on children (e) determining the fitness to parent of adults referred from the courts and DCF in C&P and 210 cases, and (f) determining criminal competency.

As there may be other reasons to employ testing, consulting with your supervisor is encouraged.

Psychological testing is generally indicated when interview techniques have failed to generate the needed clinical data or are deemed inappropriate.

Some examples of appropriate psychological testing referrals include:

A) CSI accepts referrals from internal and external sources, including when a responsible party outside the agency makes a request that the agency considers to be appropriate and necessary and meets medical necessity that test results be made available for their diagnostic and/or planning needs. The primary clinician, after interview(s) with the client, remains uncertain as to the diagnostic classification and/or issues for the client was part of the treatment.

Psychological testing may include the assessment of Intelligence, Personality, Neuropsychological deficits, Educational Assessment, and/or such specialized testing as may be further indicated. Psychological testing is not a routine screening device for all clients, but rather an option in which specific tests can be given based on the questions and concerns addressed in a client’s individual circumstances.

2.4 Long Term Expressive Play Therapy

Long-term expressive individual play therapy primarily geared for traumatized children who were victimized by child abuse, incest, neglect or commercial sexual exploitation.

Community Services Institute (CSI) is dedicated to the rehabilitation of serious and chronic trauma victims often served by DCF, DYS, and homeless agencies. CSI works closely with state agency caseworkers in court-ordered treatment for the children from families known to have suffered from several generations of using drugs, violence, sexual abuse, and criminality.

Long-term expressive play therapy is the treatment of choice for children who have been exposed to chronic trauma based on the following reasons:

Child trauma victims are often mandated by courts under state agency supervision to be receiving treatment along with their parent(s). DCF often requires that the child continue in treatment as a condition of the Service Plan. Long term expressive play often serves as a monitor that indicates the possibility of re traumatization of a child during the course of the Service Plan.

2.5 Short Term Play Therapy
Short term play therapy is a technique that lasts from 4-6 months and is often directive and active. This approach is often used for the siblings of victims as well as for adjustment.

2.6 Family Therapy

Family therapy for the multi-stressed family is strength based and focuses on techniques such as behavior management, executive strengthening of single parent households, strength-based family therapy, negotiation oriented therapy for welfare CRA conflicts, bridge-work to prepare families for the return of a child from substitute care, intervention-oriented therapy to deal with the denied chemical dependency of a parent, and couples therapy to treat a wide variety of parent couple problems that impact the safety and welfare of children.

2.7 Case Consultation

Case consultations are conducted as a component of all clinical services and may occur as a distinct service with schools, courts, state agencies, community programs and various professionals of other agencies involved with the care of the client. CSI works on a strong macro-systemic philosophy that relies on active involvement of the clinician in the various social systems of the client.

2.8 Psychiatric Evaluation

Psychiatric evaluation is geared primarily to (a) assess the need for a psychopharmacologic intervention usually related to mood disorders, ADD, violence and explosiveness, and sleep disorders (b) differential diagnosis and Individualized Action Plan (IAP) ning for complex cases.

2.9 Medication Review

Medication Review is an ongoing process which is comprised of the psychiatrist/APRN and the clinician working together to monitor all medications prescribed. With rare exceptions, CSI exclusively off this service to clients engaged in active, ongoing therapy. All clients are provided with regular follow up appointments. Clinicians provide ongoing therapy updates, within the electronic medical record, to medication prescribers.

2.10 Expert Witness Services (Springfield Office)

CSI is active in testifying in court on evaluations done for DCF and DYS. Expert witness services for child abuse cases are a cornerstone of the close relationship with DCF. These services are not generally covered by insurance and are provided by professionals either as a courtesy to the court or are reimbursed separately by state voucher or private payment.

2.11 Crisis Intervention

Clinical staff are available 24 hours, 7 days per week for crisis intervention for clients in therapy. Emergency visits are utilized as indicated to decrease the use of more restrictive settings such as hospitals and substitute care. When clinically indicated, clients may be referred to a crisis team or emergency room.
2.12 Individual Therapy

CSI offers a full spectrum of individual therapy ranging from short-term to long-term styles. Individual therapy may be expressive, dynamic, supportive, directive, or reality-based. Each individual therapy contract is flexible and negotiated between the client and therapist, then approved and monitored by the clinical supervisor and ultimately the MDT.

2.13 Family Consultation

CSI offers consultation to critical family members actively involved with a client who is in any form of treatment at CSI. These consultations are used to improve the overall quality of life of the client and to update critical family members of the client's progress in therapy at CSI.

2.14 Couples Therapy

CSI offers couples therapy that involves the couples in a process of acquiring improved communication, problem-solving and conflict resolution skills so that relationship resilience and adaptability to life stressors and day to day functioning is enhanced.

2.15 Group Therapy

CSI may offer groups that are convened based on the interest expressed by the clinicians within CSI as well as in response to the needs expressed by the larger community as well. Groups typically last for 60 to 90 minutes and have a minimum of 3, or maximum of 10 members.

2.16 Home Visits

CSI offers home visits to those clients who are unable to be served on CSI's premises. Requests for home visits are evaluated as part of the Comprehensive Assessment phase or initial referral. Home-based services will be assigned as therapists are available. To ensure confidentiality, documents which are generated in the context of a home visit will be kept under the direct supervision of the treating therapist until they are brought to the clinic for placement in the client file, electronically maintained at the agency.

2.17 Outreach Stations

When services are provided at an outreach station, the treating therapist will insure that an outreach station agreement is signed by the responsible party at the outreach station site. A Memorandum of Understanding (MOU) will be drafted and specific to the site/affiliation, and signed by the Director of Clinical Services.

2.18 Therapeutic Mentoring

Therapeutic Mentoring services are provided to youth (under the age of 21) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and in other community
settings such as school, child care centers, or respite settings. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. Therapeutic Mentoring services are provided according to the established treatment goals in concert with a CBHI clinical hub provider. Interventions include supporting, coaching, and training the youth in age-appropriate skills and behaviors, such as interpersonal communication, problem-solving and conflict resolution, and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities. TM promotes a youth’s success in navigating various social contexts, learning new skills, and making functional progress in the community.

2.19 Community Support Program

The Community Support Program is a short-term program which offers intensive case management services to clients who are in need of assistance to establish linkages with needed resources. The program offers mobile, flexible assistance to clients who would otherwise be unable to access such resources.
III. SERVICE AVAILABILITY

3.0 Access to Services
Access to services is defined as those situations that affect a client's ability to make contact with needed mental health services.

3.1 After-Hours Telephone
CSI is connected to a 24 hour, 7 days per week telephone service. During the initial visit, clients are provided with an emergency access notice which details how they can access help after hours. Clients must call the applicable CSI main office number at all times. Clinicians are required to notify their clients of this procedure and review this practice as part of the therapeutic contract. These measures are taken to ensure that each client understands how to access help by telephone prior to an incident arising.

3.2 Personal Phone Use Related to Client Contact
Clients cannot initiate contact to a clinician's personal phone. Clinicians opting to use their personal phone to communicate with clients must block the number called from. If your personal phone does not have a block already in place, you may block the number from Caller ID on a call by call basis by dialing *67 prior to dialing the client number. This ensures clients do not mistakenly call a clinician's personal phone during crisis.

3.3 After Hours-Clinic Visits
Clients who need to be seen by their therapist after normal clinic hours may arrange this with their therapist who will have access to the premises, as well as backup if needed.

3.4 Non-Discrimination
Clients will not be denied mental health services on the basis of race, sex, age, or the presence of any physical or emotional handicap that may obstruct from access to needed services.
IV. INTAKE POLICIES AND PROCEDURES

4.0 Admissions

Clients will be admitted to CSI for mental health services according to the following procedures which are applicable to anyone seeking services from CSI.

4.1 Admissions criteria

- Have a diagnosable mental disorder as set forth in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders- fifth edition (DSM-5).
- Be a willing participant in the design of the treatment.
- Have available insurance to cover the fee or be able to negotiate a mutually acceptable for self-pay.

4.2 Geographical Areas Served

Our Dorchester satellite site primarily serves towns located in the Greater Boston Area, including outlying suburbs. Our Springfield facility primarily serves the towns located within Hampden County, with limited services in Hampshire and Franklin county districts, and their surrounding rural communities.

We will accept clients from outside these areas for services at either site if there is reason to believe that they are able to present themselves at the clinic on an agreed upon schedule, and have the ability to complete a course of treatment, taking the possible distance issues into account. We will accept clients from outside these areas who require off site services if we have staff available at either site whose schedule and caseload make it practical for them to see such clients, and to complete a course of treatment with that client.

In the event that we decline to accept a client, based on geographic location or related issues, we will attempt to refer them to a service in their area.

4.3 Initial Client Contact

All clients requesting services from the Institute are required to participate in a full intake procedure that begins with the client, client guardian, or third-party referral agent calling or visiting the Institute to provide basic Referral information. The standard intake begins with the collection of the basic demographic data, background information, living arrangements, custody/guardianship status, and history of the problem, precipitating events, and referral objectives. Insurance information is provided to verify client’s insurance eligibility.
4.4 Case Disposition

Once the referral has been administratively processed, the intake department personnel assign the case to the next available clinician for a diagnostic work-up.

Once assigned, the clinician is required to make phone contact within 48 hours of receiving the intake and arrange for the first diagnostic appointment.

After the diagnostic sessions are completed one or more of the following dispositions will be reached:

**Individualized Action Plan (IAP) created:** the clinician decides with the client that the referral problem could be effectively dealt with in the clinic and an Individualized Action Plan (IAP) is created, and reviewed with the client. The treatment proceeds, subject to any UR or MDT modifications. The therapist will indicate the review of the Individualized Action Plan (IAP) with the client by documenting the review in the record, or having the client sign the Individualized Action Plan (IAP).

**Referral:** the clinician and the client decide that another service would better suit the client’s needs, and then the clinician works with the client to refer him/her to the appropriate resource.

**Further Diagnostics:** A determination is made that either a battery of psychological tests and/or a psychiatric assessment is necessary before formal treatment can proceed; the results will determine whether a referral is made or an Individualized Action Plan (IAP) created.
V. REFERRAL PROCESS

5.0 Intake Process

All intakes at CSI will be processed according to the following procedures which begin after the initial referral contact is made by the client or referring party.

The therapist begins the intake by contacting the referral agent or client by phone. The nature of the referral is discussed and plans for a first meeting are made.

At the first meeting, the therapist is responsible for clarifying the exact nature of the referral and outlines the role of therapy or evaluations and clarifies the functions of the therapist. This is followed by a discussion of the boundaries of communication, just exactly what kind of information will be treated as confidential and what can be communicated to whom. This process culminates in the completion of the releases of information, as necessary.

The client is also given a copy of the patient’s rights, HIPAA policy and asked to read them and ask questions as needed. The clients are also told about the clinic off-hour policy and how to access the clinic in an emergency. The client is also asked to review and sign the Acknowledgement of Receipt and to indicate that they understand their rights.

The client is then informed of the need for a medical examination and for the results to be obtained by the clinic. The client is shown the Medical Release of Information which outlines the choices for documentation of client’s status and gains release for the clinic to obtain the relevant medical records. The client is asked to sign the Release of Medical Information.

The client’s releases and a request for medical records are sent to the client’s physician or clinic. The therapist then outlines the steps in designing the treatment. This begins with the diagnostic evaluation period, the development of the initial Individualized Action Plan (IAP) and regular Individualized Action Plan (IAP) reviews. The client is engaged in such a
manner that his point of view is elicited and active participation in the planning and evaluation of the treatment is elicited and made explicit in this process.

5.1 New Referrals-Outside

New referrals typically are called into the clinic by a prospective client, a state agency representative, court officer, a client's parent, or another interested third party.

The first step involves determining the relationship of the referral agent to the prospective client. If the client is referring him/herself or is the legal guardian of the client, then critical client information can be obtained according to the format in the Therapy Request Form.

If the referral agent is not the client or guardian, basic information may be taken, subject to review and confirmation with the client.

Each referral must include the client name, legal guardian's name, address, home and work phone, client DOB, client's residence if different from legal guardian, referral name, agency (if any), and phone, as well as information on family composition, insurance information, service requests, and a brief history of the problem and other agencies involved. Each referral must also inquire into any medical problems and current medications of any prospective client. Special circumstances and deadlines for specific services should also be ascertained upon referral of the client.

Once the referral is taken in person or by phone, the Therapy Request is then sent to the Intake Coordinator and Billing Department for further processing. Once cleared administratively, the referral is ready for assignment. The assigned clinician initiates contact with the client/referral agent to initiate the initial visit.

5.2 New Referrals-In Clinic

In the course of treating one client, a family member or friend may request services as well. With client consent, the referral can be made by the clinician through the existing channels by
filling out the Therapy Request Form, submitting the Request for administrative review, and then participating in the selection of the appropriate clinic resource for the identified need.

5.3 Walk-In Clients

Any client who walks into the clinic without a prior appointment or in crisis shall be interviewed by the first available professional staff to determine the status of the client requesting services.

If a client is in an emergency situation, the professional staff will contact the Emergency Services Team responsible for the geographical area in which the client lives. The professional staff will insure that the client has had an opportunity to consider available options, and will be available for consultation as needed.

If no emergency exists, the professional staff will encourage the client to fill out a Therapy Request Form to initiate therapy services.

5.4 Linkages to Other Services

Any prospective client seeking services at CSI who for any reason decides themselves or in conjunction with a CSI professional staff that CSI services are not desirable or appropriate will be given the opportunity to review any and all referral information concerning other available services that may be applicable to the prospective client’s stated problem.

A professional staff will also be available to follow through any initial contact to another resource given client’s interest for such assistance and with appropriate consent. No client will be left to fend for themselves after deciding that CSI services are not for them. CSI will attempt to link the prospective client in need to the appropriate service.

5.5 Services to Minors
Service provision to minors is contingent upon the **full** consent of a custodial parent or legal guardian. Consent is formalized through written releases guardians additionally provide necessary background information as it applies to children’s care.

In the circumstance that a child is in the temporary or permanent custody of DCF or DYS, the assigned caseworker will sign the appropriate releases and provide necessary background information.

Minors in the full time physical custody of a foster parent are required to have the DCF or DYS caseworker or the custodial parent’s permission and signature on releases prior to treatment.

### 5.6 Continuity of Care

Clients who seek treatment at CSI or who leave treatment at CSI will be afforded every possible consideration to insure that they have a continuity of care.

Clients no longer receiving care at CSI will be informed of their right to information and their right to have information about their treatment at CSI forwarded to their new service. Also, all CSI professional staff is required to respond to any requests for information from a new service provider within a maximum time frame of 10 working days following receipt of the request and a signed release.

Clients who engage with CSI and then subsequently decide on another service will be informed that they have the right to have the CSI professional staff contact the new provider regarding data which was generated during their contact with CSI with proper written releases are obtained.

Clients in need of additional community resources which are beyond the scope of those provided within CSI programs, will be helped to identify resources through consultation with CSI staff. Every effort will be made to provide the client with the level of assistance needed to ensure that appropriate resources are secured. If the client is a minor, then the guardian or DCF will be involved and this process will occur with the consent of and in consultation with these providers. In instances where DCF or DYS have ultimate authority in the cases the case manager will be responsible for the resource referral, and the CSI therapist will consult with the case manager to insure that the needed services are identified.

### 5.7 Client Notification of Rights

At their first meeting, all clients will be presented with the Notification of Client Rights, Notice of Confidentiality and Limits of Confidentiality, and will have an opportunity to discuss them with
the CSI professional staff. After a full discussion and acknowledgement of understanding, the client is asked to sign that they have read and understand their rights.

5.8 Client Notification of Emergency Procedures

At the first meeting with a CSI professional staff, every client or client guardian will be provided with a copy of CSI’s After Hours Emergency Policy as well as, instructions on how to access help by phone after hours. The client will be informed of the backup system which is in place in the event their assigned clinician is not available. In that case, a supervisor or Administrator may be available to address their concerns during those alternative timeframes.

Clients will be oriented to the scope, as well as, the limits of outpatient care and further informed about the clinic’s policy concerning voluntary and involuntary hospitalization. A contact person will be identified and recorded in the client’s clinical file in case of an emergency in which assistance may be necessary to safely carry out an emergency hospitalization.

5.9 Physical Examination Requirement

Clients who are seeking treatment at CSI are asked to release the results of their most recent physical examination. If they have not had a physical examination in over 6 months, they are asked to arrange for one as soon as possible. Staff is required to document discussion around this issue in the client’s clinical record, encourage the client to comply as soon as possible, and to offer recommendations concerning options for access to a physical examination when the client does not have a relationship with a physician.

When a client who has not provided results of a recent physical exam is being evaluated for medication, extra efforts will be made to collect any necessary physical exam data (including drug history) by the first medical personnel to see the client for these purposes. The nurse or physician consulting with such a client will again request them to provide relevant physical exam results, and again document that request. When prescribing medication without further physical exam results would jeopardize a client’s health in the opinion of the authorized prescriber involved, they should refuse to prescribe such medication until the necessary information has been obtained. When prescribing medication, the prescribing party will document in his/her session note whether adequate physical status information has been received. When requested information has not been received they will document what efforts have been made to attempt to obtain that information. When a client who is medicated has not provided all requested physical status information (including drug history), the prescribing party will document what ongoing efforts are being made to obtain that information.
The referring therapist and Psychiatric Department Coordinator will be responsible to ensure that all clients requesting medication have had a recent physical, or indicated their willingness to have one in writing. If they have had a recent physical, they will be asked to identify the physician and sign a release of information. When such releases are received, office support staff will send the release to the identified physician and keep a log of such mailings, which can be found in the electronic health record (EHR)
VI. TREATMENT PLANNING

6.0 Treatment Procedures

All treatment procedures at CSI will follow specific guidelines that are designed to ensure the most appropriate level of care possible.

6.1 Case Assignment

Each case is assigned to a therapist for the initial diagnostic procedure. Case planning begins after the first session when the therapist has a beginning idea about what the referral problems are and just what level of response will be required. Case planning begins in individual or group supervision, refined through the Multidisciplinary Team Review process (within 3 sessions), and monitored through regular case review procedure. Where applicable, case conferences will be utilized to ensure a comprehensive planning process.

Therapist assignments are made by the Intake Coordinator based on availability, specialty, experience, and other specific case factors such as race, religion, or gender. Assignments are made when these factors are germane to the client. If there are no associated family members in need of services or if it is determined that family therapy alone is indicated, the case is assigned in total to a specific therapist. If there are other referrals within clinic to be made, then the therapist and supervisor in conjunction with Review Team members construct a workable schedule of therapy or diagnostic services for the client and or his/or family.

All clients are afforded a thorough diagnostic evaluation prior to the initiation of therapy. The initial evaluation includes at least the following information: Name, DOB, Chief Complaint, Psychosocial History, Precipitating Events and Major Stressors, Developmental History, History of Symptoms, Significant Life Events, Family History, Previous Psychiatric Hospitalization or Treatment, Relevant Medical History, Mental Status and DSM-5 diagnosis.

6.2 Individualized Action Plan (IAP): Definition

All clients referred or seeking treatment from CSI are first engaged in a thorough Comprehensive Assessment session prior to the initiation of treatment. All treatment follows a medical model in which the identified problem is analyzed from a multi-disciplinary framework and treatment is designed to reflect both a short term and a long term set of goals that reflect the most direct route to improved level of functioning. Since many of CSI’s
referrals are concerned with child protection, the treatment designs often focus on the most dangerous aspects of a client's or their family's functioning. Risk assessments are utilized in order to identify and address the most acute aspects of client's functioning.

6.3 Individualized Action Plan (IAP): Timeline

The initial Individualized Action Plan (IAP) is due within 21 day of the commencement of care. This plan based on findings of the initial assessment phase, results in the identification of the specific concerns which determines the focus of treatment. The plan additionally identifies the interventions to be employed in the service of the outlined goals and objectives. Individualized Action Plans (IAP) incorporate both short and long term goals, and outline a time frame for achievement, as well as criteria for determining when termination of treatment is appropriate.

6.4 Individualized Action Plan (IAP): Goals and Style

Goals and style of therapeutic interventions are specific to each specified problem, reflect the modality of the intervention whether it is individual, family, group, couple, and also indicate what ancillary in-clinic, as well as community resources are to be utilized to reach specified goals.

Individualized Action Plans (IAP) delineate measurable outcomes for each intervention. The specific outcomes need to reflect the expected impact of the intervention on the client's level of functioning. Short and long term outcomes must be delineated in such a way as the therapist's supervisor and the Review Team can clearly assess whether the intervention that is planned is meeting the specific goals outlined by the therapist.

6.5 Individualized Action Plan (IAP): Client Involvement

Clinicians are to involve clients in the planning process. Clinicians elicit and incorporate the client’s point of view on the goals and the nature of the treatment interventions. Clinicians are also required to document this discussion in the clinical file.

6.6 Individualized Action Plan (IAP): Case Conferences

All cases are subject to conferencing in the following manner:
Supervisory Conference: Supervisor will review each case in supervision on a schedule determined by the level of criticality/complexity in the case.

Utilization Review Conference: Universal case reviews are conducted within 90 days of intake by the UR committee. Any resulting comments and a signature of approval are required from the UR committee. Specific conferences may be suggested by the UR committee with itself or another designated supervisor or group within the clinic.

Case Review Conference: Each case is reviewed by a member of the multidisciplinary team on a biannual basis at minimum, and more frequently, if indicated by the unique circumstances or requirements.

In the event that a case conference indicates a service gap of 30 days or more, a disposition is determined, resulting in whether an inactive notice or discharge summary is generated.
VII. MEDICATION POLICIES AND PROCEDURES

7.1 Medication Policy

The clinic will provide psychopharmacology services through its psychiatrist or prescribing nurse under the supervision of the Medical Director. Clients qualify for a referral for these services when:

A) Demonstrate a mental disorder for which a known course of medication treatment has been shown to be effective. Treatment interventions which are undocumented or lacking proper substantiation by research are prohibited, AND

B) Request medication and for whom the clinic psychiatrist believes will be helped to live more productively by the medication.

Involuntary prescribing of medications is prohibited. CSI does not directly administer medication on site. The scope of psychopharmacology services consists of evaluation, monitoring of progress, adjustments in dosage and side effects monitoring of client response and documentation of all services provided.

7.2 Referral for Medication Evaluation

Referrals are generated by the primary clinician, upon client consent and supervisory review and signature. Every appointment with the clinic psychiatrist or APRN is made by the Psychiatric Coordinator or clinical staff member. The clinic does not provide these services to individual who are not engaged in regular active therapy for at least 3 months unless approved by the Director of Clinical Services. However, circumstances in which the client is referred for services following an inpatient admission or psychiatric emergency will be prioritized at the discretion of the supervisor and administrative staff.

7.3 Permission to Prescribe Medication

Once medication is deemed necessary by the clinic psychiatrist or APRN, written permission must be obtained from a client's guardian, if the client is a minor. For clients in state custody, anti-psychotic medications require permission of the court or parent.
7.4 Required Steps for Prescribing

When prescribing medications, the clinic psychiatrist or Psychiatric APRN will:
A) Discuss a follow up visit schedule.
B) Inform the client of the possible side effects and provide written information on this if necessary
C) Inform the client of the advisability of calling the clinic psychiatrist or psychiatric APRN should any problems arise before the next scheduled meeting
D) Arrange for the primary therapist to be advised of the medication status of the client.

7.4 Medication Monitoring

All medications will be monitored. Medication and/or follow up therapy reviews will be scheduled and the results will be made available to the therapist who will also report back regularly to the clinic psychiatrist or APRN on the efficacy of the medication from the perspective of the primary therapist.

All medication clients, even those considered stable, will have medication reviews scheduled, at a maximum of 6 month intervals. Clients who remain inconsistent with attendance at medication reviews as scheduled will be terminated from active psychopharmacology.

All medications prescribed will be duly logged in the client’s EHR.

7.5 Medication Monitoring - Client No Show or Cancellations

When a client does not attend a scheduled medication review, but requests continuation of medication, the prescribing staff member will determine if prescriptions can be continued without seeing the client. Based on the available information regarding client’s reports and/or treatment staff recommendation the client’s history of compliance with medication reviews, level of current need for medication, likelihood of medication abuse, possible side effects of withdrawal, and other relevant factors, the prescribing staff member will weigh the benefits and risks of prescribing with the benefits and risks of failing to prescribe, and act accordingly. When such a prescription is written, it will be of a duration which coincides with the next scheduled medication review, commencement of services at another facility, or other time limited event which will be consistent with sound medical judgment.
7.6 Medication: Administrative Responsibility

The staff psychiatrists and/or psychiatric nurses are directly responsible to the Medical Director concerning the prescription, monitoring, and counseling of clients involved with prescribed psychiatric medications. The Medical Director meets as needed with the medical staff to review medications prescribed and the client progress on the medication. The psychiatrist or psychiatric nurse is responsible to communicate with the treating clinician or their supervisor to obtain and dispense relevant information about client progress on medication.
VIII. UTILIZATION REVIEW

8.0 Utilization Review: Definition

Utilization Review (UR) is a process by which a multidisciplinary team reviews the treatment of clients at critical points, to insure that the diagnostic information and the Individualized Action Plan (IAP) are congruent, and that the treatment and goals are relevant, and measurable. The UR team insures quality control by performing the functions identified in the plan, for those clients who require this process.

8.1 Utilization Review Team

The UR team consists of senior clinicians and or supervisors:

A) The utilization review committee is to review each of the center’s cases at least in the following circumstances:
   1) Within 90 days of initial contact;
   2) When a recipient has required more than 50 visits every 12 months and has not required hospitalization or extensive crisis intervention during that period; and
   3) Following termination.

B) The utilization review committee is to verify for each case that:
   1) The diagnosis has been adequately documented;
   2) The Individualized Action Plan (IAP) is appropriate and specifies the method and duration of the projected treatment program;
   3) The Individualized Action Plan (IAP) is being appropriately implemented;
   4) The Individualized Action Plan (IAP) is being or has been modified as indicated by the recipient’s changing status;
   5) There is adequate follow-up when a recipient misses appointments or drops out of treatment; and
   6) There is progress towards achievement of short-and long-term goals.

C) No staff member is to participate in the utilization review committee’s deliberations about any recipient he is treating directly.

D) CSI will maintain minutes that are sufficiently detailed to show the decisions of each review
and the basis on which any decisions are made so that the Department may conduct such audits as it deems necessary.

E) Based on the utilization review, the Director of Clinical Services or her designee is to determine whether continuation, modification, or termination of treatment is necessary and promptly communicate this decision to the primary therapist.
IX. DISCHARGE PROCEDURES

9.0 Termination Process: Definition

The Termination Process begins when the client or the therapist communicates the need for termination or when client participation indicates that treatment is not useful. Once this decision has been reached, a referral needs to be completed to insure continuity of care, or other arrangements made with or for the client in order to guarantee access to services at CSI or another service if the client desires.

9.1 Criteria for Termination

Clients who are ready for discharge will be involved in termination discussions. Therapists are instructed to utilize supervisory consultation to determine when the treatment is nearing completion either through therapeutic impasse or as determined by the realization of stated treatment goals.

Termination Criteria Include:

Treatment goals are reached in either the client's or the therapist's view.

Irresolvable barriers to sustained engagement such as chronic no shows for appointments or irregular attendance that reaches a point that the therapist concludes, in consort with his/her supervisor, that the treatment goals are unattainable through the clinic's services.

The Director of Clinical Services, supervisor, and/or the therapist believe that the treatment progress is stagnant and that a referral or termination is the best course of action. Administrative termination of benefits in which the client declines to negotiate a fair rate of compensation for private mental health care.

Sudden or planned relocation.

9.2 Termination Summary

Once a decision to terminate has been reached by the therapist with the approval of the supervisor and/or Director of Clinical Services, a Discharge Summary is prepared by the therapist and submitted for approval to the MDT team.
The Termination Summary must indicate the intake date, the most recent diagnosis, the reason for referral, the goals, and any progress made in therapy.

The Termination Summary needs also to provide some concrete recommendations to sustain progress and/or for further treatment or services for the client, if so indicated.

The client should be notified of their discharge and a written summary is available for release upon request.

9.3 Follow Up and Referral

All clients are informed at discharge that they can re-refer for services at a later date, should the need arise. Any prearranged future contacts will be noted in the discharge summary. Clients who have been involuntarily discharged due to various reasons, such as requiring a higher level of care or non-compliance with therapy appointment policy are able to make a referral for services after 6 months from termination and a clinical review for the appropriateness of services.

If a client leaves treatment without notice, the therapist is required to discuss this with his/her supervisor, and follow up with a letter to the last known address or with a phone call asking the client to participate in a review or termination process. If this is not possible, the therapist should inform the client of other alternatives within the clinic as well as in the community. The therapist is also responsible to advise clients of the possibility for re-referral at a future juncture is possible if circumstances change. All clients will be engaged in co-joint planning for follow up their own improvement through the use of available community resources. Efforts will be extended by CSI therapists to follow through on helping the client link up with desired services following treatment at CSI.
X. EMERGENCY SERVICES

10.0 Emergency Services: Definition

Emergency Services are those services offered by CSI to those clients who are active in treatment. If a client is in need of emergency assessment, the answering service will contact the on-call clinician, who will then further assess the situation and refer as necessary to the local Crisis Team or Emergency Room/911.

10.1 Emergency Services: Coverage

CSI provides coverage for their psychiatric emergencies in the following manner:

The 24 hour, 7 days a week answering service has a list of all the clinicians active at CSI. The service can also reach one of the backup clinicians when the client's therapist is unavailable.

CSI's schedule of coverage ensures that there are always 2 backups available by phone. This coverage is prearranged and communicated via supervisor. Senior clinical staff share emergency and off hours back up responsibilities.

10.2 Definition of Emergency

An emergency is defined as the following:

- Client is suicidal or homicidal
- Client is in danger of hospitalization
- Client is in danger of residential care or more restrictive placement
- Client is unable to cope with feelings or moods or reports the inability to cope with any symptom or stressor.
- Other emergency as defined by client or emergency called and deemed appropriate by the clinician involved.

10.3 Emergency Procedures: Operating Hours

The following protocol is to be followed should an emergency arise for a client during normal clinic operating hours. The following steps should be taken:
The client’s therapist should be contacted immediately.

If the therapist is available, then the clinician needs to arrange for an emergency visit. If the client's therapist cannot respond in time to prevent harm or hospitalization, then the next available clinician or the Director of Clinical Services should be contacted to make a plan for responding to the emergency. In any case the client needs to be informed at every step of the efforts being made.

If the client is losing control and is at imminent risk of harm to himself or others and cannot wait for any emergency response, then, the clinician must call the police from the client's town as well as the appropriate emergency service provider from that area posted at the clinic.

If a client has an emergency on the clinic premises which require transport to the hospital, the following transport options will be considered:

1. A family member or friend of the client will be contacted to provide transport.
2. Ambulance or emergency services will be contacted.
3. A staff member may provide transport.

10.4 Emergency Procedures: Off Hours

NOTE: Upon intake all clients are to be provided with written copy of CSJ’s off hour emergency policy, as well as, the contact information for their local emergency service provider.

Should a client be in need of emergency services during the off hours, they are to call the 24-hour service who in turn will try to reach the client's therapist. If the therapist cannot be found by phone, then, the service will contact the covering senior clinician.

In response, the client will be contacted first by phone by the clinician identified by the service.

The clinician or backup will spend the necessary time with the client on the phone to determine the nature and severity of the problem. If the problem requires no personal contact, the therapist or back up will provide the necessary intervention and safely planning if applicable, by phone and arrange for the earliest possible opportunity for a personal contact with the therapist or back up.
If the client is in imminent danger of harming him or herself or someone else, the therapist or the backup will first try to make sure that the client can promise not to hurt them self or others while the therapist or back up attempts to contact an immediate support person in the client's family or immediate neighborhood.

If the client cannot make this promise, the therapist or back up will call the local police and the local Emergency Services Agency to alert them of the imminent danger. The therapist or the backup will then work with the client to arrange transportation.

The therapist or back up at this point may elect to ask the client to come into the clinic or visit the client at his or her home to insure their safety and then proceed to engage the emergency services of the police or the designated Crisis Team in the client’s catchment area.

Once the client safety in ensured, then the therapist can participate in the emergency evaluation of the client by providing the Crisis Team with relevant background, if necessary, or in any other way to help arrange for an effective crisis intervention. Arrangements to follow up with any necessary records of medications or treatment history can be made when a client's crisis treatment location is determined.

10.5 Emergency Services: Documentation

All emergency calls will be documented in the client's file and further will be relayed to the primary clinician in the event that back up becomes involved. This documentation will take the form of a clinical note that becomes part of the client's clinical file. A copy of this note is also sent to the primary clinician. Any emergency visit will be documented with an Emergency Session Note.

10.6 Emergency Services: Follow Up

All emergency visits or phone contacts will be followed up by a regularly scheduled therapy session with the primary clinician to review the situation and to plan for preventive interventions in the future that may reduce the possibility of future emergencies.
All emergencies that involve suicidal or homicidal behavior will also be followed by an in-house supervisory evaluation to assess the risk of continuing outpatient care. Referral to psychiatric evaluation will occur if indicated.

10.7 Emergency Services: Primary Clinician’s Responsibilities

Following every emergency service, it is essential that the primary clinician immediately contact those involved in the provision of the emergency services and gather as much data as possible about the crisis, its precipitating factors, and the eventual resolution of the crisis.

Further, the primary clinician is directed to schedule an appointment with the client to review the crisis and plan for more productive responses in the future.

If the client is hospitalized, the primary therapist needs to contact the hospital social worker or contact person to exchange information and plan for the client’s release and establish a role for the primary clinician during the client’s hospitalization. Upon release, the primary clinician needs to meet with the client as soon as possible.

10.8 Emergency Services: Suicide References

When a client makes statements relating to possible suicide, and the therapist hearing such reports believes there is a high risk involved, the client should be referred for an immediate review by our psychiatrist, or referred to a crisis team. If the therapist receiving such reports believes there is little or no risk of suicide, and that therapist is not independently licensed (L.I.C.S.W., Ph. D., M.S.N., or M.D.), the therapist should consult A.S.A.P. with one of our psychiatrists or a multi-disciplinary team member to verify that no crisis referral is required. Referral to crisis assessment or consultation on risk must be documented on a session note or other note to the client file.
XI. EMERGENCY HOSPITALIZATION

11.1 Psychiatric Hospitalization: Process

CSI clients who in the course of their therapy may need to be placed for their own or someone else's safety in a hospital will be accorded the swiftest and safest response that will access the least restrictive hospital setting possible given the nature of the crisis.

11.2 Psychiatric Hospitalization: Voluntary

Voluntary (Springfield): Call the Holyoke Hospital or Baystate Child Psychiatric and inquire about bed space. Inform the client of the procedure for admission. If the client does not desire to go to Holyoke Hospital or Baystate, then make him or her aware of the alternatives such as Wing Memorial Hospital, Noble, or Franklin Medical Center. After bed space is located in a suitable hospital, then arrange with the client or guardian or family member to safely transport to the hospital. After the client is safely at the hospital, the therapist should follow up with a call to the hospital to plan for continuity of care.

Voluntary (Dorchester): Same as above except contact Faulkner Hospital.

11.3 Emergency Hospitalization: Involuntary

Involuntary Contact the local Psychiatric Emergency Team for an emergency assessment. If they determine an involuntary commitment is necessary, they will follow through. If not, follow the Voluntary Procedures.

If the client remains at risk despite the Crisis Team's evaluation, the primary therapist or back up needs to try to convince the client to get to a hospital.

If this is unsuccessful, the therapist or back up needs to obtain a promise not to hurt oneself or others and also needs to try to arrange for the client not to be alone during the crisis.
XII. INCIDENTS

12.1 Serious Internal Incidents: Reports

Serious incidents occurring on the clinic premises which seriously affect the health and safety of patients shall be reported to the Administrator in writing within 3 business days of occurrence. Items 1-4 below shall be reported immediately to the Administrator. At a minimum, the following events shall be identified as serious incidents:

1. FIRE
2. PATIENT SUICIDE
3. SERIOUS CRIMINAL ACTS
4. PENDING OR ACTUAL STRIKE ACTION BY EMPLOYEES

A report shall be filed with D.P.H. by the Administrator within one week of the occurrence of such an event. If one of the events listed above in 1-4 occurs, the Administrator shall call D.P.H. immediately.
XIII. QUALITY ASSURANCE POLICIES AND PROCEDURES

13.0 Quality Assurance: Definition

Quality Assurance is the sum total of CSI activities at all levels that is designed to improve the quality of care provided to the center's clients.

13.1 Case Conferences, Mass Health Clients

A multidisciplinary team will conduct case conference meetings and will perform the following in conjunction with the primary therapist:

(1) Within four client visits, prepare a comprehensive written Individualized Action Plan (IAP) that is based on the initial evaluation, incorporates short- and long-term treatment goals, and establishes criteria for determining when termination of treatment is appropriate;

(2) Review all of the recipient's Individualized Action Plan (IAP) s and updates and enter into the recipient's records an updated statement of the problems, goals, and treatment activities and, if indicated, a reformulation of the Individualized Action Plan (IAP); and

(3) Review each case at termination of treatment and prepare a termination summary that describes the course of treatment, aftercare arrangements, program or resources to which the recipient is directed post termination.
13.2 Interdisciplinary Collaboration

All cases are reviewed by members of a multi-disciplinary team (including a Psychiatrist as appropriate). The team consists of a Psychiatrist, Psychologist, and Social Worker, Psychiatric APRN and/or any appropriately licensed professional. The multi-disciplinary team reviews all Individualized Action Plans (IAP). Individualized Action Plans (IAP) and progress notes are reviewed at least each 6 months.

When the Psychiatric Advanced Practice Registered Nurse (APRN) participates (s)he will work closely with the psychiatrist and/or the Medical Director in coordinating the medical and medication needs of the clients. The APRN then works directly with the therapist and/or client on the implementation of the medical plan.

The psychologists work closely with the treatment staff on test results to aid in differential diagnosis, as well as with therapists and clients on interpreting test results and helping integrate the information into the treatment.

Social workers and counselors regularly interact and collaborate in case planning and strategic interventions.

13.3 Administrative Responsibility for Cases

The Clinic Administrator is responsible for the accurate maintenance of all clinical and administrative documentation related to the progress of all cases. The Clinic Administrator works closely with the Billing and Records Department to ensure that all the required documentation and administrative procedures are complete and accurate within the specified timeliness required by regulations. All questions concerning eligibility, fee reductions, or client/referral agent complaints are the direct responsibility of the Clinic Administrator, or his/her designee.

Direct supervisors meet regularly with therapists and review the design and progress of all cases. Reviews of all therapists’ performance are prepared within the first six months of employment and at least annually thereafter. Supervisors review the clinical documents of their respective supervisee and use this information to verify compliance with supervisory process.

Supervisors are responsible to discuss and approve all transfers and terminations prior to submittal to the Review Team. Supervisors also are responsible to work with their respective supervisee on any feedback received through the Utilization Review Process or the Case Review Process.
Supervisors are also responsible for initiating special case conferences on difficult cases. Supervisors are responsible for guiding the treating therapist to look at counter-transference issues throughout the course of the treatment and are also responsible for insuring that all the appropriate ancillary services have been engaged during the course of treatment.

13.4 In-Service Training

Special Interest discussions with a strong didactic orientation on various topics related to the practice of therapy is offered once monthly, at minimum.

All staff are allowed an allotment for their educational advancement through outside seminars and CEU training, approved by their clinical supervisor.

Medical staff are encouraged to participate in outside CEU training to maintain industry best practice of care.

Psychologists receive seminars on test interpretation as well as on-going supervision for every test battery administered. Psychology Department Meetings are held to discuss all aspects of testing and consultation.

13.5 Staff Evaluation

All staff are routinely evaluated both administratively and clinically:

When hired, all clinical staff are given an administrative review schedule that begins with a 3-month trial, and then extends to 6 month reviews, and may extend to yearly reviews. This evaluation relies on feedback from:

- Consumer satisfaction phone interviews with clients
- Structured and unstructured feedback from referral agents
- Feedback from the billing department
- Structured evaluation from clinical supervisor

The Clinical Supervisor conducts the review in consultation with the clinician and the Director of Clinical Services, who negotiates rate increases. In the event of performance problems, progressive discipline and/or a corrective plan is drafted.
All clinical staff are evaluated throughout the course of their tenure at the clinic. Clinical supervisors meet to discuss techniques for improving and evaluating staff’s performance as needed. Each clinical supervisor is responsible for evaluating his/her respective clinicians and reporting formally to the Director of Clinical Services and/or Clinical Administrator. The following criteria are used in clinical staff evaluation:

- Skill and efficacy of initial and sustained engagement of clients.
- Assessment and Diagnostic skills.
- Treatment and Intervention planning
- Clinical documentation skills.
- Ability to meet referral objectives.
- Case organization/conceptualization.
- Follow through on the Individualized Action Plan (IAP) in weekly sessions.
- Interdisciplinary and interagency collaboration and advocacy
- Ability to involve clients in the design and implementation of planned strategies.
- Termination and case closure skills.

Any staff disagreeing with any aspect of his/her evaluation is advised to request a hearing with the Clinic Administrator or Trustee. This request for a hearing must be made in writing by the staff to the Clinic Administrator and a hearing scheduled within 5 working days from the date of the request.

### 13.6 Quality Assurance Program

Quality assurance activities are conducted by a committee composed of the Director of Clinical Services and Administrator (or designees) and any additional staff deemed appropriate. In the event that the committee is pursuing issues related to medical policy, the Medical Director will be involved.

The committee will focus on a particular issue of concern to the program each year, such as appropriateness of intake procedure, length of time clients spend on waiting list, M.D.T. procedures etc. The committee will compile information on the focus issue. At the close of the focus period, the committee will report its findings, and implement a plan to implement changes to practice on policy, where appropriate. The committee may refocus its efforts if a more compelling issue presents itself.

The Director of Clinical Services will monitor the activities of the quality assurance program, and submit the results to the governing body for annual review.
XIV. CLIENT GRIEVANCES

14.1 Client Grievance Procedure

In an effort to maintain the highest quality of care for CSI clients, the Institute maintains a client grievance procedure that will offer the clients an official way to file a complaint about any aspect of care.

14.2 Client Grievance: Guiding Principles

Clients may direct informal verbal complaints to therapist or his/her supervisor. The therapist or supervisor will respond verbally to minor complaints. Serious complaints will be referred to the Administrator. They may also file a formal written grievance with the Administrator.

Written grievances will be responded to within 48 hours by the Clinic Administrator or designee Therapists are required to direct all clients’ grievances to a clinical supervisor.

14.3 Client Grievance Process - Formal

Clients are directed to notify the Clinic Administrator of their complaint either by phone or in writing.

The Clinic Administrator will respond within 48 hours by phone or written memo to the client who initiated the grievance. Clients are offered a meeting to be scheduled within 7 working days from receipt of the grievance.

The Clinic Administrator reviews the grievance and offers recommendations for rectification.

The Clinic Administrator will then meet with the involved clinic personnel to review the grievance and to outline a plan for the rectification of the problem.

The Client is subsequently notified by phone and/or in a letter from the Clinic Administrator and apprised of the actions taken to rectify the matter generating the grievance.
Involved staff are then informed in writing of the resolution plan for the problem leading to the client grievance.

In the event that the grievance is determined to be unfounded, the client and any staff involved will be notified.

XV. SMOKING AT THE CLINIC

15.0 Smoking Policy

Smoking is not permitted anywhere on CSI premises
XVI. ADMINISTRATION

16.0 Business Management System

CSI has a business management system which revolves around computerized data entry and adjustment. Payroll related information is processed through an electronic payroll system that accounts for all deductions and related items for payroll, as well as produces monthly, quarterly, and annual statements.

Information on all checks paid out (as well as all bills produced and collections made) is entered into an accounting software program that sorts the above into categories as needed, and then relates them to existing budgets, sources of income, and larger accounting issues.

A budget is produced at minimum, annually, and entered into a computer program which allows it to be compared to actual income and expenses on a monthly basis, at minimum. The program further allows for an analysis of variances from the budget that allows for projections of the implications of the variance within any category for any specified time period.

All the above information is directed to the Controller, who prepares it in a summary form that is presented to the Clinic Administrator at least monthly. The Clinic Administrator is responsible to make decisions about any changes in data collection or presentation, as well as concerning any funding or programmatic changes which may be necessary to reconcile projected income and budgeted expenses with actual income and expenses.

A Certified Public Accountant reviews the clinic’s finances and systems minimally, on an annual basis, and reports to the Trustees his/her findings and recommendations. The accountant will also be contacted as needed in the event that significant financial variance or questions arise. The Trustees set guidelines and limits for the Clinic Administrator based on accountant’s reports, Clinic Administrator’s performance, and the program’s effectiveness and needs. In addition, the Trustees conduct routine and random inquiries as they see fit to insure overall compliance with financial needs and goals.

16.1 Statistical Information

CSI receives raw information in a variety of forms relating to client information, service utilization, and finances. Each staff member who receives this information is required to compile it in such a way as to submit it to entry into a computer system or written logs.
CSI has designed custom tracking and management information software that allows for very close monitoring of all information collected and further allows for a variety of analysis reports of desired combinations of entered data.

Current reports contain monthly summaries of basic client data such as: service hours, types of services, bills submitted, sources of funding, referral sources, collections, and accounts outstanding.

16.2 Client Tracking

CSI utilizes a customized tracking system, which allows for the development of formulas to track whether bills for client services meet the guidelines for available service units, presence of required clinical documentation, Prior Approval Status, co-payments, and other relevant data.

Therapists are given printouts of their client’s status as needed.
XVII. COMMUNICABLE DISEASES

17.0 Communicable Disease Policy

CSI is committed to actively participating in the prevention of the spread of communicable diseases among staff, among clients, and between staff and clients and as consistent with all established regulations.

17.1 Communicable Diseases: New Staff

All new staff are responsible as part of initial hiring, to provide CSI with documentation that they are free from communicable diseases. This report is made part of the permanent personnel record.

17.2 Communicable Diseases: Acquired by Staff

Any staff that contracts a reportable communicable disease while employed by CSI is responsible to report such disease to his or her supervisor who then reports to the Clinic Administrator and Medical Director.

If it is determined that a staff member has a communicable disease, they will cease activities which involve contact with staff or clients, or take such medically acceptable precautions to prevent the spread of disease as are appropriate.

17.3 Communicable Diseases: DPH Reporting

All CSI staff are responsible for reporting to DPH any clients known to be infected with a reportable communicable disease if those clients have not already seen a medical professional. A full list of reportable diseases in Massachusetts is detailed in 105 CMR 300.100: REPORTABLE DISEASES, SURVEILLANCE, AND ISOLATION AND QUARANTINE REQUIREMENTS, effective July 2008.

17.4 Communicable Diseases: Sanitation

CSI provides routine maintenance service which uses disinfectants to clean all public areas and rest rooms.
17.5 **Communicable Diseases: Play Materials**

CSI requires that play material utilized in the waiting rooms or as part of the play therapy at the center, to be washed or disinfected after use/as appropriate to prevent the possible spread of infection. In addition, such materials are stored above ground level to prevent recontamination.

Clients will not be permitted to use stuffed animals. If on site, they will be for display use only.

Any equipment which is contaminated by contact with clients or staff with a communicable disease will be washed and/or disinfected as appropriate.

17.6 **Communicable Diseases: Staff with Active Illness**

Any CSI staff that is infected with a communicable disease or infection is encouraged to seek medical care and to refrain from client or staff contact while in the active infectious stages.

17.7 **Communicable Diseases: Cleanliness**

CSI requires that the center premises be thoroughly cleaned at least weekly and encourages all staff to manage their own areas and keep them clean in between scheduled cleanings.

17.8 **Communicable Diseases: Client with Active Illness**

In addition to any reporting requirement which may exist, the therapist of any client with a communicable disease will do one of the following:

A) Reschedule appointments until contagion has passed, or

B) Where feasible, see the client at home or alternate site, or

C) Make arrangements for an in clinic visit such that the client is segregated from other clients/staff to the maximum extent possible.
XVII. FEES

18.0 Fee Policy

CSI has an established fee policy which reflects the usual and customary charges for all services offered at the clinic. This schedule is attached in the Appendix and reflects standard fair pricing within the industry. In the event that a client holds two or more insurance policies, the primary insurer will be the first billed.

18.1 Fee Reductions

Clients seeking a fee reduction may apply for such through his or her therapist, who will document this in a Fee Reduction Form which is submitted to the Clinic Administrator for review and comment within 7 working days.

18.2 Non-Payment of Fees

CSI will not accept any client into treatment who does not have the resources to continue in treatment for the amount of time necessary to accomplish the stated goals at referral. A detailed plan of expected fees is provided to the client prior to beginning treatment. Financial limitations that may arise are discussed with the client.

In the event that the client has limited resources, he is offered the fee reduction schedule and will be allowed to pay according to a schedule that is comfortable and manageable.

Clients unable or unwilling to follow this procedure will be allowed sufficient time and assistance to transfer to another service. The CSI therapist will be active in working with the client to find a more appropriate service.

18.3 Cancellation Procedure

The clinic schedules its appointments with the expectation that all appointments made will be kept. Since circumstances beyond a client's control may arise from time to time, cancellations are accepted made 24 hours in advance of appointment without prejudice. Cancellations with less than 24 hours' notice, multiple cancellations, or missed appointments, may result in restriction from further appointments. This practice is provided to clients at the initial visit and acknowledgement of understanding is obtained in writing.
All cancellations are to be communicated directly with the therapist scheduled to be seen if that therapist is unavailable, a message will be conveyed by the receptionist.
XVIII. CLIENT RIGHTS

19.0 Client Rights

All clients at CSI will be given a copy of the Patient Rights.

19.1 Client Rights: Posting

A copy of the Patient Bill of Rights will be clearly posted in the waiting area of the center.

19.2 Client Rights: Violation

Any violation of Client Rights should be reported to DPH Division of Health Care Quality 1-800-462-5540 or 1-617-727-8984. Clients will be informed of this process.

19.3 Client Privacy in Treatment Rooms

To ensure client privacy, the following measures are ensured. When services are provided at the clinic in rooms with glass in the door, the blinds on such rooms will be drawn while the client is present, unless safety or legitimate clinical concerns dictate otherwise. The waiting room and each hallway area near treatment rooms will have a white noise machine present, which will be turned on when sessions are in progress. The Director of Clinical Services will monitor compliance.
XX. RECORDS POLICIES AND PROCEDURES

20.0 Records: Retention

Client medical records (including test reports) will be maintained for 20 years. Raw data from psychological test reports will be maintained for 5 years.

20.1 Records: Content

Intake sheet with all important demographic and identifying data, including name, address & telephone number of client, case number, D.O.B., date of initial contact, gender, responsible party, and medical assistance #, where applicable:

- Releases of Information
- Medical Authorization Form
- All medical records acquired from other providers and doctors
- Signed HIPAA/confidentiality rules and signed patient rights sheet
- Comprehensive Assessment
- Initial Individualized Action Plan (IAP) with all subsequent updates
- Transfer Form (if applicable)
- Session notes for each service
- Medication use profile
- Discharge Summary
- Relevant written correspondence
- Psychological Testing Reports
- Psychiatric Assessments
- The dates for scheduled Utilization Review
- Name, Qualifications and Discipline of the Primary Therapist

Note: Corrections to records will be made in accordance with appropriate medical records corrections practice.

20.2 Records: Maintenance, Storage, and Destruction

All records will remain in the clinic and cannot be removed without expressed written permission of the Medical Director or Administrator. The records will be maintained in a
locked cabinet and/or in a restricted records area. Most records are now maintained electronically.

Records that have expired will be disposed of by a professional service or on-site shredding after any necessary notifications. Electronic records will be erased.

20.3 Release of Client Records

All client records will be maintained with the utmost of confidentiality and consistent with HIPAA regulations. These measures are taken to protect the release of the fact that the client is in treatment and in addition protects release of any content of treatment at CSI whether written, verbal, taped, or in any other way which could directly reflect on any client activity at CSI.

20.4 Written Releases

No document referring to any client at CSI may be released to anyone but the client or the client’s legal guardian without proper consent. Permission must be documented in the form of a dated and signed release. The signature must be from the client, if 18 or over and capable of informed consent, the client’s legal guardian or the Guardian Ad Litem will be qualified to provide consent in the event that the client is not capable of informed consent due to age or other rendering circumstances.

CSI clerical, billing, or administrative staff are prohibited from confirming that a client is in fact engaged in services at CSI Clarity on this directive is ensured as a component of employee orientation.

No CSI professional staff will communicate verbally with any party (except client’s legal guardian) concerning a client’s treatment without written consent, as per above.

20.5 Client’s Rights to Clinical Records

Any CSI client 18 or over has a right to view or have a copy of their clinical record. Copying fees are the responsibility of the client requesting the documents.

Any client wishing to view and then discuss their clinical record will be offered a meeting with a CSI professional staff member to do so.
20.6 Client Identification

Every page of the client’s record will contain at minimum the client name, date of birth, and client number in order to identify accurately the information associated with the client.

20.7 Availability of Records to Professional Staff at CSI

Professional staff at CSI are allowed to review the records of other clients at CSI only when the purpose of the record review contributes to the planned ongoing quality of care for the client. Casual review of other client’s records is strictly prohibited.

20.8 Disclosure of Information upon Subpoena

CSI will respect any valid subpoena for records if the notice is duly served. Upon receipt of the notice, the records clerk will attempt to narrow down exactly what is desired by the court. Summaries will be sent unless all documents are specified by the court’s subpoena. Release of any records to subpoena must first have the approval of the Clinic Administrator or designee.

20.9 Limitations of Confidentiality

Social Workers as a group, Licensed Mental Health Counselors as a group, and psychologists and psychiatrists as a different group are protected independently by law from disclosing the contents of therapy. The situations vary considerably and may require various levels of legal response. Therefore, any social worker, counselor, psychiatrist, or psychologist who is asked to divulge potentially harmful information about a client is required to report such a condition to the Clinic Administrator or his/her designee who may seek legal counsel to study the individual circumstances.

20.10 Duty to Warn

All professionals are required to warn any potential victim of an act, believed by the clinician, to be of immediate danger to the potential victim and are required to both report such a threat to the identified potential victim as well as warning the local police of the potential of harm to the identified victim to the therapist by any client.
XXI. INFORMED CONSENT

21.0 Informed Consent

Clients must have the ability to make an informed consent before agreeing to waive any rights to confidentiality or any other patient right under Public Health Laws. It is the responsibility of the clinician to verify the status of every client’s ability to give informed consent.

XXII. STAFF

22.0 Staff Composition

CSI’s staff consists of professional staff including psychiatrists, psychologists, social workers, counselors, and others as the program may require; as well as clerical and administrative staff.

22.1 Ongoing Staff Supervision

Regular ongoing group or individual supervision will be carried out according to the following protocols:

Psychiatric APRNs are supervised by the Medical Director, and offer peer consultation.

Unlicensed clinicians are supervised by an LICSW/ LMHC/ or Licensed Psychologist supervisor one time per week, or as is consistent with their caseload and level of professional development.

All unlicensed psychologists are supervised by a Massachusetts Licensed Psychologist.

Nonprofessional staff working in a clinical capacity will be supervised by a fully qualified professional staff member trained in one of the clinics core disciplines.

The Medical Director and the Director of Clinical Services are responsible to the Administrator.

Each clinical supervisor is to keep a log of all scheduled supervisory sessions. At a minimum, these logs will indicate supervisee’s name, date of contact, and type of supervision.

22.2 Psychiatrist: Qualifications and Responsibilities
Currently certified or eligible for certification by the American Board of Psychiatry.

Licensed physician in the second year of a psychiatric residency program accredited by the Council on Medical Education of the American Medical Association. This psychiatrist must be under the direct supervision of a fully qualified psychiatrist.

Primary responsibilities include Utilization Review, evaluations, prescription of psychiatric medications, medication follow up, assessment of dangerousness, and the consultation of diagnostic formulations.

22.3 Staff Psychologist; Qualifications and Responsibilities

Licensed as a psychologist by the Mass Board of Registration of Psychologists or Masters’ degree or equivalent graduate study in clinical or counseling psychology or related specialty from an accredited educational institution or be currently enrolled in or have completed a doctoral program in clinical or counseling psychology or closely related field, and 2 years’ full time supervised clinical experience subsequent to obtaining a Masters’ Degree in a multi-disciplinary mental health setting. (One year of supervised clinical work in an organized graduate internship program may substitute each year of experience). All but Fully Licensed Psychologists by the Mass Board of Registration will be supervised by a Mass Licensed Psychologist.

Responsible for the administration of psychological tests, interpretation, and formulating diagnosis based on testing, as well as the full range of therapy and supervision and Utilization Review (if licensed).

22.4 Professional Staff: Qualifications and Responsibilities

Minimum requirement for any professional staff providing diagnostic and therapy services is a Masters in Counseling or Social Work with 2 years’ post Masters experience (or internship equivalent) in a multi-disciplinary setting, independent licensure in social work, or independent licensing in their respective fields or such other qualifications as licensure or insurer guidelines may require. All professional staff will perform to the levels outlined in the Department of Public Health and Insurer regulations governing the delivery of the particular service delivered by the professional staff, excluding those reserved for physicians.

Professional staff are responsible for the delivery of the full range of therapeutic modalities and diagnostic services.
22.5 **LICSW Social Worker: Qualifications and Responsibilities**

MSW from an accredited school of social work with a LICSW license granted by Massachusetts Board of Registration in Social Work.

Duties include direct client services, supervision of non-independently licensed social workers and Utilization Review and MDT activity.

22.6 **Director of Clinical Services: Qualifications and Responsibilities**

Maintains overall levels of professional standards as they relate to licensure, statutory regulations, and quality of clinical and professional behavior. This position provides a critical link amongst the various subdivisions within the agency, providing a unifying and operationalizing quality standard amongst the diverse types of projects active within the clinics. Springfield and Dorchester clinics each have their own Director of Clinical Services, and they collaborate between clinics.

**Requirements:**

1) Must be licensed, registered, or certified to practice as a psychiatrist, psychologist, social worker, counselor, or psychiatric nurse, have at least five years of full-time supervised clinical experience subsequent to obtaining the Masters’ degree (two of which must be in an administrative capacity) and be capable of working with various types of professionals under the same mental health umbrella. The Director of Clinical Services must also be independently licensed in his or her field.

2) Responsible for overseeing the quality of clinical care being delivered by duly licensed individuals or by individuals who are supervised in the way congruent with existing regulations for third parties as well as for various training programs.

3) Program Development activities including being available to develop specialized internships and be active on boards and committee to allow students from various professions to function as clinical staff and receive the appropriate supervision.

4) Coordination of the Utilization Review Committee, both participating as an active member as well as coordinating other professionals among the multi-disciplinary teams.

5) Responsible for interfacing with supervisors around specific concerns from Utilization Review.

6) Responsible for acquiring the necessary signatures on required documents which pass through the utilization process.

7) Development of in-service training for professional staff.
Clinical Supervision:
1) Responsible for providing staff supervision as necessary.
2) Responsible for insuring the supervision of supervisors, working closely with the various clinical directors, and direct service staff as indicated.

Administrative:
1) Responsible to approve the selection of clinical staff, and insure that a complete staffing schedule is maintained.
2) Approve all job descriptions and assignment of staff.
3) Approve policies and procedures for patient care.
4) Conduct program evaluations as needed or required.

Duties:
1) Minimum of 5 years' full time, supervised experience subsequent to obtaining a Masters' degree in either social work, psychology, psychiatric nursing, or psychiatry. Two years must be in an Administrative capacity

22.7 Medical Director: Qualifications and Responsibilities

The Medical Director must have an M.D. and be certified or eligible or qualified and applying for certification by the American Board of Psychiatry and Neurology.

Requirements:
1) Licensed M.D., certified or eligible and applying for certification by the American Board of Psychiatry and Neurology.
2) It is recognized that for the purposes of these items, "practice of medicine" or provision of "medical services" shall not be construed as ongoing psychotherapy services provided by psychologists, social workers, counselors, or other not licensed to practice medicine, and that the psychotherapy services are normally supervised as needed by other professional staff members.
3) It is also understood that the medical director may from time to time provide supervision for such ongoing psychotherapy services when requested to do so, or when the medical director's attention is directed to an unusual set of circumstances that would necessitate direct supervision of such services.
Duties:

1) Provide or supervise all services involving the practice of medicine, when such services are provided by the clinic.*
2) Be present at the clinic when medical services are provided, unless another physician is present, or such medical services are provided pursuant to written protocols or guidelines by a physician assistant or nurse practicing in an expanded role in accordance with the regulations of the appropriate registration board.*
3) Prescribe and monitor medications when appropriate.
4) Evaluate non-psychiatric, physical health problems when reported/observed, and make referrals for same, when appropriate.
5) Establish and supervise medical policies.
6) Participate in utilization and case appropriate.
7) Provide case consultation when necessary.
8) Participate in the clinic’s quality assurance program for the mental health program.
9) Be on call for emergencies during clinic operating hours and after hours 24/7/365.
10) Oversees supervision of all medical staff, sets medical policy, and participates in Utilization Review/Case Review as needed.

22.8 Clinic Administrator: Qualifications and Responsibilities

Responsible to Trustees to oversee all aspects of the administration of all departments of the clinic.

Requirements:

1) Must have training in Business, Social Work, Education, Psychology, or related field plus experience applicable in administering community mental health programs.

Duties:

1) Oversee clinic operations.
2) Consult with CFO on all financial matters.
3) Organizational development and goal setting.
4) Oversee UR/MOT process.
5) Facilitate management meetings.
6) Address DCF complaints.
7) Interview prospective therapists.
8) Clinical and administrative supervision of Director.
9) Oversee Psychology department.
10) Direct the Psychology internship program.

22.9 Verification of Licenses
All licensed staff must have a valid license from the duly authorized source on file at all times.

22.10 Job Descriptions

JOB DESCRIPTION: CEO, PRESIDENT

Duties:
1) Public Relations
2) Organization and development planning.
3) Attend MHSACM meetings.
4) Provide 2 hour weekly training for psychology interns.
5) Facilitate clinical trainings for staff, supervisors, and managers.
6) Provide direct psychotherapy, parent assessments/legal evaluations.
7) Attend management meetings.
8) Monthly clinical supervision.

JOB DESCRIPTION: CLINIC ADMINISTRATOR

Requirements:
1) The clinic Administrator must have at least a Masters’ degree in business, social work, education, psychology, or related field, plus have a minimum of five years’ experience in administering community mental health programs, and be skilled in personnel management, finances, and be knowledgeable of Medicaid policies, Department of Public Health policies, and other policies guiding operations of a clinic.

Duties:
1) Oversee clinic operations.
2) Consult with CFO on all financial matters.
3) Organizational development and goal setting.
4) Oversee UR/MDT process.
5) Facilitate management meetings.
6) Address DCF complaints.
7) Interview prospective therapists.
8) Clinical and administrative supervision of Director.
9) Oversee Psychology department.
10) Direct the Psychology internship program.

JOB DESCRIPTION: DIRECTOR OF CLINICAL SERVICES

Requirements:
1) The Director of Clinical Services must have at least a Masters’ degree in business, social work, education, psychology, or related field, plus have a minimum of five years’ experience in administering community mental health programs, and be skilled in personnel management, finances, and be knowledgeable of Medicaid policies, Department of Public Health policies, and other policies guiding operations of a clinic.

Duties:
1) Oversee daily operations of the clinic.
2) Organizational development and goal setting.
3) Address internal/external agency complaints.
4) Facilitate monthly staff meetings.
5) Facilitate communication between Springfield and Boston offices.
6) Oversee psychiatric and intake departments.
7) Oversee UR/MDT process.
8) Oversee Medical Records department to ensure compliance with regulatory bodies.
9) Oversee quality assurance plans.
10) Supervision of clinical supervisors, and support staff.
11) Coordinate clinical and staff coverage.
12) Liaison with HR Manager regarding personnel matters and policy/procedure development.
13) Recruitment of all professional and office staff:
   a. Phone screening, interviewing, and reference checks.
15) Set pay rates of clinicians for both locations.

JOB DESCRIPTION: HR MANAGER

Duties:
1) Oversees all company accounting practices, including accounting and payroll departments, preparing budgets, financial and billing reports, tax and audit functions.
2) Processes approval for all company expenditures.
3) Confer with clinic Administrator in order to direct financial strategy, planning and forecasts.
4) Studies, analyzes and reports on trends, opportunities for expansion and projection of future company growth.
5) Participate as part of management team including attendance of monthly meetings.
6) Liaison between management team and technology consultant.
7) Oversee recruitment, hiring, and termination of all personnel.
8) Draft and implement policies and procedures in coordination with clinic administration.
9) Processes annual reviews and increases.
10) Maintain personnel files and update clinical credentialing in accordance with regulatory bodies.
11) Oversee personnel time and accrual records in accordance with company policies.

JOB DESCRIPTION: PSYCHIATRIST

Requirements:
1) Currently certified (or eligible and/or applying for certification) by the American Board of Psychiatry and Neurology or  
2) Licensed physician in the second year of a psychiatric residency program accredited by the Council on Medical Education of the American Medical Association. If hired under category B, such psychiatrists must be under the direct supervision of a fully qualified psychiatrist.

Duties:
1) Responsibility for the evaluation of the physiological, neurological, and psychopharmacological status of the center's clients.  
2) Involvement in diagnostic formulations and development of Individualized Action Plan (IAP) as needed.  
3) Direct psychotherapy when indicated.  
4) Participation in utilization review or quality assurance activity as needed.  
5) Coordination of the center's relationship with hospitals and provision of general hospital consultations as needed.  
6) Supervision of, and consultation to, other disciplines as assigned by the Medical Director.

JOB DESCRIPTION: PSYCHIATRIC ADVANCED PRACTICE REGISTERED NURSE (APRN)

Duties:  
1) Evaluate and diagnose patient.  
2) Develop Individualized Action Plan (IAP) to include medication as appropriate.  
3) Order and interpret labs and test as appropriate.  
4) Communicate/collaborate with other providers.  
5) Consult with supervising physician on regular basis.  
6) Precept nurse interns.  
7) Upper management coverage as necessary.

JOB DESCRIPTION: CHIEF PSYCHOLOGIST

This is a leadership position within the Psychology Department, and in many ways in the agency an experienced person capable of working with subordinates, and peers in other disciplines as needed.

Requirements:  
1) Licensed by the Massachusetts Board of Registration of Psychologists, with a specialization in clinical or counseling psychology, or a closely related specialty.

Duties:  
1) Will be designated as a member of the Utilization Review Committee, and be responsible to insure that all utilization and case review (as required by regulation and agency policy) is conducted and signed off by the psychology discipline.  
2) Will work with staff and/or supervisors to insure that any utilization/case reviews which are deemed unsatisfactory are adjusted by the staff member submitting them, and once again
reviewed and signed off.

3) Will provide treatment and assessments of clients as needed and will consult with other licensed psychologists as needed.

4) Will provide supervision for non-licensed psychologists according to their need and in compliance with applicable regulations.

5) May provide supervision and/or training experiences to other disciplines if so requested by the Director of Clinical Services.

6) Will consult with other supervisors and program directors as indicated by the Director of Clinical Services.

7) Will report to the agency Administrator, and provide other services as indicated by the agency Administrator.

JOB DESCRIPTION: CLINICAL SUPERVISOR

Duties:

1) Supervision of clinicians
2) Maintain small client caseload.
3) Provide clinical coverage and on-call backup coverage.
4) Coordinate clinical presentations for staff meetings.
5) Collaborate on annual reviews of assigned clinicians.
6) Assistant to clinic administration on special projects.
7) Training/in-service to psychology interns as needed.
8) Clinical staff interviewing, as needed.
9) Participate as part of operations team and attend weekly meetings.
10) Maintain supervision log.
11) UR-MDT responsibilities

JOB DESCRIPTION: OFFICE MANAGER - SPRINGFIELD

Duties:

1) Administrative support to President, Administrator, and Director of Clinical Services.
2) Responsible for interviewing, training, and supervising receptionist and transcriptionist.
3) Maintaining voice mail system and liaison with answering service.
4) Coordination of mail distribution, in/out.
5) Tracking and ordering all office supplies.
6) Scheduling and assisting with all inspections (i.e.: Department of Public Safety, Fire Department, etc.).
7) Coordinating vacation schedules and sick days for direct reports.
8) Oversee/manage equipment issues.
9) Liaison with landlord regarding building issues and systems.
10) Oversee office space scheduling for clients/staff meetings.
11) Attend monthly supervision with Director of Clinical Services.
12) Attend weekly operations meeting
13) Process insurance authorizations
14) Coordinate billing

JOB DESCRIPTION: INTAKE COORDINATOR

Duties:
1) Process intakes; verify insurance; distribute service requests, and tracking disposition of cases.
2) Serve as agency contact person for questions regarding wait list/status of cases.
3) Submit monthly data reports to insurers/funders.

JOB DESCRIPTION: PSYCHIATRIC COORDINATOR

1) Responsible for the administrative operation and support of the psychiatric department, including triaging phone calls and requests for the prescribers.
2) Coordinate scheduling of psychiatric appointments to include interface with clinicians regarding no show/cancellations. Liaison with receptionist to ensure provision of reminder calls and the rescheduling of all identified open slots.
3) Oversee adherence of the psychiatric attendance policies.
4) Utilize and serve as agency contact person for Rcpia/ eHana.
5) Oversee therapist update/medication review process including tracking and maintenance of documentation exchange between clinicians and psychiatry.
6) Assist Director of Clinical Services with Psychiatric department quality assurance project.
7) Serve as contact person for drug representatives.
8) Maintain sample supplies IAW regulations.
9) Respond to records requests according to established guidelines.
10) Attend monthly operations meeting.
11) Attend bi-weekly supervision with Director of Clinical Services.

JOB DESCRIPTION: MEDICAL RECORDS COORDINATOR

Duties:
1) Creating and maintaining client records; filing; performing periodic chart audits; prepare paperwork/charts for UR/MDT process.
2) Respond to requests for information releases and submit to Director of Clinical Services/designee for approval prior to release.
3) Provide administrative support for Trainer and/or Director of Clinical Services.
4) Maintain inventory of clinical forms.
5) Provide reception/phone coverage as needed.
6) Backup coverage for therapy intakes.
7) Attend operations meeting (weekly in Springfield; biweekly in Boston).
8) Attend biweekly supervision with Director of Clinical Services.
JOB DESCRIPTION: PROFESSIONAL STAFF

This position represents the direct care personnel including all therapists, psychologists, and psychiatrists, and psychiatric personnel that deliver; psychotherapeutic or evaluative services to clients at the center whether they be in-office or in-home services.

Requirements:
1) Minimum qualifications for professional staff are a Masters’ degree in Counseling or related field, with two years’ experience in a multi-disciplinary setting, independent licensure in social work, or independent licensing in relative fields, or be license eligible in a related field.
2) All professional staff will perform to the Department of Public health and Medicaid or insurance carrier regulations governing the delivery of that particular service.

Duties:
1) Provide individual family or diagnostic services as indicated by specialty.
2) Responsible for maintaining knowledge of current guidelines for performing any direct clinical service at the clinic.
3) Responsible for maintaining a high level of professionalism in responding to the clients.
4) Responsible for the accurate representation of their clinical activity in the form of service documentation, which is required for submission on a weekly basis.

Administrative:
1) Responsible for accurate and timely submission of clinical documentation as set forth in the clinical documentation manual.
2) Responsible for accurately submitting all expense statements as previously arranged.
3) Responsible for negotiation all tasks to ensure timely and accurate insurance authorizations are in place for all needed services.
4) Responsible for keeping in touch with the office on a daily basis, checking e-mail and voicemail and responding to client’s and referral agents request for information.
5) Responsible for submitting all necessary billing and documentation in a timely fashion as agreed in contract.
6) Responsible for notifying clinic Administrator of any upcoming review dates.

JOB DESCRIPTION: THERAPEUTIC MENTOR/CSP CASE MANAGER

Duties:
1) Direct provision of Therapeutic Mentoring and Case Management services which meets agency standards for clinical practice.
2) Attend regular individual supervision, staff meetings and participate in required trainings, as to ascertain relevant clinical skills and maintain eligibility as a CBHI service provider.
3) Maintain timely and accurate submission of all clinical and billing paperwork, as per agency protocols and as established according to program regulations. This includes the drafting of
assessments, intervention plans, intake packets and weekly clinical documentation, as well as, timely initial and re authorization of insurance benefit.

4) This full time 40-hour position includes a minimum productivity component in which a quarterly average of 30 weekly billable clinical service hours of TM/CSP programming is maintained.
APPENDIX A.

Licensed Mental Health Clinic

CLIENT RIGHTS

Community Services Institute is strongly committed to respecting the basic human rights, worth and dignity of each individual receiving services. In addition, as a client here, you have the legal rights which are guaranteed by the constitution and state and federal laws and regulations. Those rights are:

The Right to Treatment
The right to have all reasonable requests responded to promptly and adequately. The right to obtain a copy of all rules and regulations which apply to clients at the agency. The right of freedom of choice in healthcare providers and information relative to financial assistance and free healthcare. The right to refuse treatment. The right to life-saving treatment. The right to refuse to be a research subject. The right to provision of adequate services from Community Services Institute (CSI), or to be referred to another agency for services unavailable at CSI.

The Right of Informed Consent
The right of confidentiality of all records and communication as provided for by law; to inspect and receive a copy of their records; a copy of a bill or statement of charges submitted; to know that information about HIV status may not be shared with other providers without written consent; to receive an itemized bill, including third party reimbursement paid toward said bill.

The Right to Protection from Mistreatment
The right of privacy of medical treatment and to obtain explanation as to the relationship, if any, of the physician to any other healthcare facility or institution as said relationship relates to their treatment.

The Right to Competency
The right to request the name and specialty of any person responsible for care or coordination of care.
APPENDIX B.

**FEE SCHEDULE**

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual, Family, Couple Sessions, and Case Conferences</td>
<td>$125.00</td>
<td>per 45/60 min.</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>$50.00</td>
<td>per 90 min.</td>
</tr>
<tr>
<td>Psychiatric Consultation</td>
<td>$200.00</td>
<td>per 50 min. (3)</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>$1500.00</td>
<td>per battery</td>
</tr>
</tbody>
</table>

1. When sessions of longer or shorter duration are scheduled, fee will generally be proportionate to the time difference.

2. Typical fee for a standard full assessment, then only specific, limited, tests are requested. Recommended fee will be based on the individual test(s) administered.

3) Please note:

The clinic will accept Medicaid payments and payments from other insurers when the clinic has a contract for "payment in full," as satisfying the above fee schedule.

Fee reduction requests will be considered from those who cannot afford full payment. Fee reduction forms are available from the business office.
Appendix C.

COMMUNICABLE AND OTHER INFECTIOUS DISEASES REPORTABLE IN MASSACHUSETTS BY HEALTHCARE PROVIDERS*

*The list of reportable diseases is not limited to those designated below. This list includes only those which are primarily reportable by clinicians. A full list of reportable diseases in Massachusetts is detailed in 105 CMR 300.100.

Animal bites should be reported immediately to the designated local authority.

Important Note: MDPH, its authorized agents, and local boards of health have the authority to collect pertinent information on all reportable diseases, including those not listed on this page, as part of epidemiological investigations (M.G.L. c. 111, s. 7).

COMMUNICABLE AND OTHER INFECTIOUS DISEASES REPORTABLE IN MASSACHUSETTS

*The list of reportable diseases is not limited to those designated below. This list includes only those which are primarily reportable by clinicians. A full list of reportable diseases in Massachusetts is detailed in 105 CMR 300.100.

Report Directly to the Massachusetts Department of Public Health, Bureau of Infectious Disease

305 South Street, Jamaica Plain, MA 02130

Isolates should be submitted to Hinton State Laboratory Institute.

HIV infection and AIDS: (617) 983-656

Latent tuberculosis infection: confidential fax: (617) 983-6220

Sexually Transmitted Infections: (617) 983-6940

- Chancroid
- Chlamydial infections (genital)
- Gonorrhea
- Gonorrhea resistant to fluoroquinolones or Ceftriaxone
- Granuloma inguinale
- Herpes, neonatal (onset within 60 days after birth)
- Lymphogranuloma venereum
- Ophthalmia neonatorum
- Pelvic inflammatory disease
- Syphilis
Reportable Diseases Primarily Ascertained Through Laboratory Testing

Please work with the laboratories you utilize to assure complete reporting.
REPORT IMMEDIATELY BY PHONE!
This includes both suspected and confirmed cases.
All cases should be reported to your local board of health;
if unavailable, call the Massachusetts Department of Public Health:
Telephone: (617) 983-6800  Confidential Fax: (617) 983-6813

• REPORT PROMPTLY (WITHIN 1-2 BUSINESS DAYS).
  This includes both suspected and confirmed cases.

isode Isolates should be submitted to Hinton State Laboratory Institute
- Anthrax
- Any case of an unusual illness thought to have public health implications
- Any cluster/outbreak of illness, including but not limited to foodborne illness
- Botulism
- Brucellosis
- Cholera
  - Creutzfeldt-Jakob disease (CJD) and variant CJD
- Diphtheria
- Encephalitis, any cause
- Hemolytic uremic syndrome
- Foodborne illness due to toxins
  (including mushroom toxins, ciguatera toxins, scombrototoxin, tetrodotoxin, paralytic shellfish toxin and amnesic shellfish toxin, and others)
  - Hansen’s disease (leprosy)
- Hemolytic uremic syndrome
- Hepatitis A (IgM+ only)
  - HBsAg+ pregnant women
  - Hepatitis syndrome, acute possibly infectious
- Influenza, pediatric deaths (<18 years)
- Infection due to novel influenza A viruses
- Leptospirosis
- Lymphocytic choriomeningitis
- Malaria
- Measles
- Meningitis, viral (aseptic), and other infectious (non-bacterial)
- Meningococcal disease, invasive
  (Neisseria meningitidis)
- Mumps
- Pertussis
- Plague
- Polio
- Pox virus infections in humans, including variola (smallpox), monkeypox, vaccinia, and other orthopox or parapox viruses
- Rabies in humans
- Respiratory infection thought to be due to any novel coronavirus including SARS and MERS
- Reye syndrome
- Rheumatic fever
- Rickettsialpox
- Rocky Mountain spotted fever
- Rubella
- Tetanus
- Toxic shock syndrome
- Trichinosis
- Tuberculosis
- Tularemia
- Typhoid fever
- Typhus
- Varicella (chickenpox)
- Viral hemorrhagic fevers
- Meningitis, bacterial, community acquired
• Anaplasmosis
• Amebiasis
• Babesiosis
• Campylobacteriosis
• Cholera
• Cryptococcosis
• Cryptosporidiosis
• Cyclosporiasis
• Dengue
  ➟ Eastern equine encephalitis ➟
• Ehrlichiosis
• Escherichia coli O157:H7, and other shiga-toxin producing E. coli ➟
• Enteroviruses (from CSF)
• Giardiasis
• Glanders ➟
  ➟ Group A streptococcus, invasive ➟
  ➟ Haemophilus influenzae, invasive ➟
• Group B streptococcus, invasive
• Hantavirus
• Hepatitis B
• Hepatitis C
• Hepatitis D
• Hepatitis E
• Influenza (➔ if antiviral resistant)
• Legionellosis ➟
• Listeriosis ➟
• Lyme disease
• Melioidosis ➟
• Norovirus
• Pneumococcal disease, invasive (Streptococcus pneumoniae) (➔ if patient <18 years)
• Pneumococcal disease, invasive, penicillin-resistant
• Salmonellosis ➟
• Shiga toxin-producing organisms ➟
• Shigellosis ➟
• Staphylococcus aureus, methicillin-resistant (MRSA), invasive
  ➟ Staphylococcus aureus, vancomycin-intermediate (VISA) and vancomycin-resistant (VRSA) ➟
• Psittacosis
• Q fever
• Toxoplasmosis
• Typhus
• Vibriosis ➟
  ➟ West Nile ➟
• Yellow fever
• Yersiniosis ➟

105 CMR 300.000 Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements. Effective December 2013
APPENDIX D.

[Diagram of organizational structure]

HR Director
- Administrative Assistant
- Office Manager

CEO/President
- CFO/Clinical Administrator

Director of Clinical Services
- Assistant to the Director
- CBHI Supervisor
- CBHI Coordinator
- Therapeutic Mentor
- MSW Internship Supervisor
- MSW Interns
- Psychological Internship Supervisor
- Psychology Interns

Medical Director
- Springfield Prescribers
- Boston Prescribers
- Nursing Intern

Director of Clinical Services
- Clinical Supervisors
- Clinical Internship Supervisor
- Psychology
- Support Staff

Director
- Clinicians
- Therapeutic Mentors
- Administrative Assistant
- Office Manager

Medical Director
- Assistant to the Director
- CBHI Supervisor
- CBHI Coordinator
- Therapeutic Mentor
- MSW Internship Supervisor
- MSW Interns
- Psychological Internship Supervisor
- Psychology Interns

Medical Director
- Springfield Prescribers
- Boston Prescribers
- Nursing Intern

Director of Clinical Services
- Clinical Supervisors
- Clinical Internship Supervisor
- Psychology
- Support Staff

Director
- Clinicians
- Therapeutic Mentors
- Administrative Assistant
- Office Manager