

OhioRISE PRTF Program Manual

Version 1.2

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Legal Disclaimer

Ohio Department of Medicaid (ODM) strives to make the information in this program manual as accurate, complete, reliable, and timely as possible. However, ODM makes no claims, promises, or guarantees about the accuracy, completeness, or adequacy of this information. This is the most current version of the OhioRISE PRTF Program Manual document, which is being released as an informational and educational tool; however, this document is subject to change and future revisions as the implementation and operations of the OhioRISE program changes. ODM, its employees, agents, or others who provide the answers will not be liable or responsible to you for any claim, loss, injury, liability, or damages related to your use of or reliance upon this information. This guidance is intended solely as an informational and educational resource for providers intending to participate in the OhioRISE program and for the public. The information contained in this document is not intended to set new standards and requirements beyond the scope of those standards and requirements found in the Ohio Administrative Code or Ohio Revised Code. In the case of any conflict between the information contained in this document and Ohio Administrative Code or Ohio Revised Code, the Ohio Administrative Code or Ohio Revised Code, as applicable, prevails. This information is not intended to be a substitute for professional legal, financial, or business advice. This document does not create, nor is it intended to create an attorney-client relationship between you and Ohio. You are urged to consult with your attorney, accountant, or other qualified professional if you require advice or opinions tailored to your specific needs and circumstances.

Section 1: OhioRISE Purpose and Goals

Ohio Department of Medicaid (ODM), supported by the Governor’s Family and Children First Cabinet Council, developed Ohio’s first-ever integrated program to help youth who have complex and serious behavioral health needs in partnership with stakeholders, providers, and partner state agencies. OhioRISE (Resilience through Integrated Systems and Excellence) aims to improve care and outcomes for these youth and their families/guardians/caregivers by:

- Creating a seamless delivery system for children and youth, families/guardians/caregivers, and system partners.
- Providing a “locus of accountability” by offering community-driven comprehensive care coordination through local Care Management Entities (CMEs).
- Expanding access to critical behavioral health services and supports needed for this population such as Intensive and Moderate Care Coordination, Mobile Response and Stabilization, Respite, Intensive Home-Based Treatment, Flexible Funds, and Psychiatric Residential Treatment Facilities (PRTF).
- Assisting youth, families/guardians/caregivers, state, and local child serving agencies, and other health providers to locate and use these services.

ODM selected Aetna Better Health of Ohio (Aetna) to serve as the specialized managed care organization for the State’s youth with the most complex behavioral health needs for the OhioRISE program. Aetna is working with ODM, partner state agencies, providers, families/guardians/caregivers, youth, and stakeholders to implement a youth and family/guardian/caregiver-centric model featuring new-targeted services and intensive care coordination delivered by community partners.

The foundation for OhioRISE and its success in supporting children with complex behavioral health needs and their families/guardians/caregivers rests in [Systems of Care](#) (SOC) principles and High-Fidelity Wraparound practice. A system of care¹ is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs to help them to function better at home, in school, in the community, and throughout life. As such, OhioRISE principles reflect:

¹ https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

- **Family/Guardian/Caregiver and Youth Voice and Choice:** Family/guardian/caregiver and youth voice, choice and preferences are intentionally sought and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family/guardian/caregiver-focused and youth-centered from the first contact with or about the family/guardian/caregiver or youth.
- **Team based:** Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. There is an expectation to participate in the Child and Family Team (CFT) to understand roles of others on the CFT providing services (including care coordination) and to incorporate services and roles into the child and family-centered care plan (CFCP) critical for ensuring service and interventions support the goal of the CFCP and ensure services to meet those goals while avoiding duplication and fragmentation.
- **Natural Supports:** The team actively seeks out and encourages the full participation of members drawn from the youth and family's/guardian's/caregiver's network(s) of interpersonal and community relationships (e.g., friends, neighbors, community, and faith-based organizations). The CFCP reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration:** The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home- and Community-Based:** Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, responsive, accessible, and normative, and least restrictive setting possible. A high-quality network of providers is important to support youth in remaining as close to families/guardians/caregivers and communities as possible.
- **Culturally Relevant:** Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the youth and family/guardian/caregiver and their community.
- **Individualized:** Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family/guardian/caregiver. The services are also tailored to meet the needs of youth with disabilities, including intellectual and developmental disabilities. They are monitored regularly and adjusted as necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths-Based:** Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of

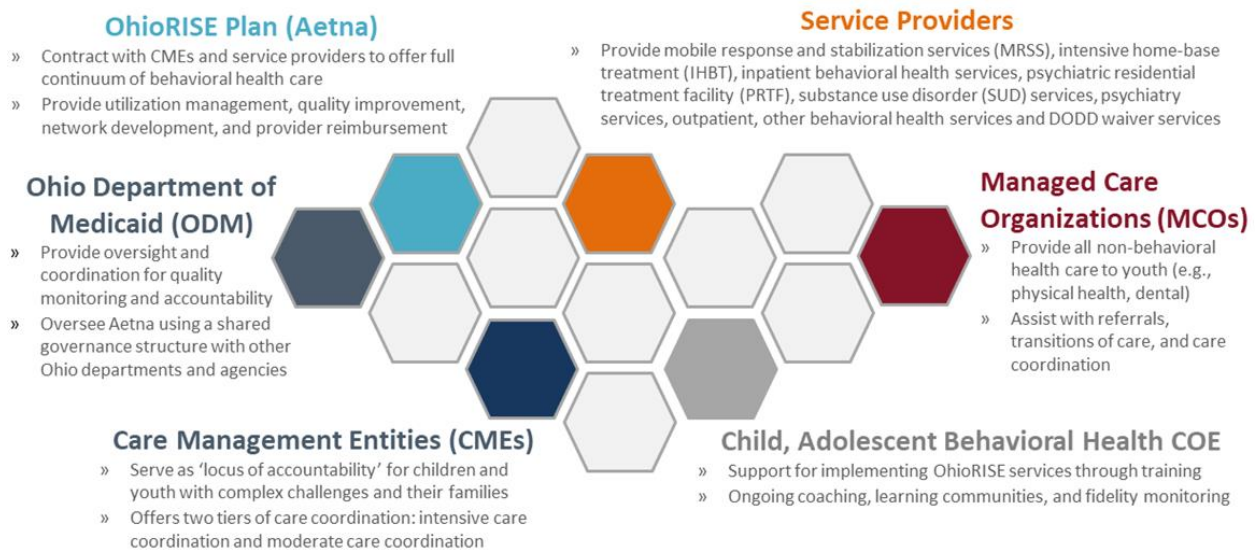
the youth and family/guardian/caregiver, their community, and other team members.

- **Outcome-Based:** Based on the youth and family’s/guardian’s/caregiver’s needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are designed to be persistent and flexible, helping to overcome setbacks and achieve their intended goals and outcomes. Safety, stability, and permanency are priorities.
- **Unconditional:** A CFT’s commitment to achieving its goals persists regardless of the youth’s behavior, disabilities, placement setting, family’s/guardian’s/caregiver’s circumstances, or availability of services in the community. The team continues to work with the family/guardian/caregiver toward their goals until the family/guardian/caregiver indicates that a formal process is no longer required. For more information related to National Wraparound Initiative visit: <https://nwi.pdx.edu/>

Section 2: OhioRISE Delivery System: Key Partners

ODM and OhioMHAS partnered to develop Ohio’s PRTF service with the input of Aetna Better Health of Ohio, Ohio’s other child-serving agencies (Ohio Department of Developmental Disabilities (DODD), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Education (ODE), Ohio Department of Youth Services (DYS), Ohio Department of Health (ODH), and Ohio Family and Children First (FCFC)) and stakeholders.

How does OhioRISE deliver its services?



OhioRISE Plan (Aetna)

Aetna Better Health of Ohio (Aetna) serves as the OhioRISE plan, a specialized managed care organization for the state's youth with the most complex behavioral health needs. Aetna serves as the point of access to PRTF and connects youth and their families/guardians/caregivers with the care they need at the right intensity of treatment.

Aetna is responsible for selecting and contracting with PRTF providers and supporting the PRTF role as part of the OhioRISE system of care continuum. Aetna is also responsible for coordinating efforts with PRTFs, CMEs and other community providers (IHBT, BH respite, etc.) to seek alternative community-based services for Medicaid enrolled youth who seek admission to a PRTF. In contracting with PRTFs and a range of behavioral health providers, Aetna will ensure availability and consistent quality for all OhioRISE behavioral health services.

Care Management Entities

CMEs are Aetna's contracted regionally based organizations that are responsible for face-to-face care coordination and comprehensive service planning for youth and their families/guardians/caregivers with intensive and moderate care coordination needs in accordance with Ohio Administrative Code (OAC) rule [5160-59-03.2](#). CMEs coordinate CFT meetings and implement CFCPs for each youth and their family/guardian/caregiver. They coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth, utilizing a Wraparound approach to care planning.

The goal of CMEs is to identify and provide linkages to necessary supports and services in the community whenever possible. Some youth experience needs during their course of treatment that may prompt the CFT to consider a higher intensity of service than can be provided in the youth's community, such as PRTF. Removing a youth from the home for treatment has a significant impact on the youth and family/guardian/caregiver and must be done thoughtfully to maximize the treatment benefit potential, reduce the youth's length of stay, maintain family/guardian/caregiver relationships, and increase sustainability of the youth's progress. Therefore, CMEs partner with the PRTF and other providers to reduce PRTF lengths of stay and successfully provide this treatment in one episode per youth.

The CME's role is to help families/guardians/caregivers succeed by developing a plan to address their needs and removing barriers that may impede progress. Their goal is to help youth and families/guardians/caregivers develop a long-term, sustainable plan that will support them in improved functioning long after CME involvement. The CFT removes barriers to care, drives care in the SOC approach, and facilitates creative, flexible planning to support the families/guardians/caregivers and youth. As such, the CME will continue to provide care coordination while a youth is receiving PRTF services, and PRTF staff are expected to participate on a youth's CFT for the duration of the youth's PRTF treatment and following a youth's

transition in order to support successful transition back to the community, school and family/guardian/caregiver. Additional discussion of collaboration with CMEs occurs in [Section 9](#) of the manual.

Collaboration with Children's Services Systems

Collaboration with service and custodial agencies such as the Public Children Services Agencies (PCSAs), Title IV-E courts and Bridges are essential to achieve the goals of the OhioRISE Program. The PRTF will work closely with local PCSAs, Title IV-E courts and Bridges regional teams in concert with the CME, in the course of work on behalf of individual youth and their families/guardians/caregivers. Additional discussion of collaboration with child serving agencies occurs in [Section 9](#) of the manual.

Section 3: Psychiatric Residential Treatment Facilities Purpose and Goals

PRTFs aim to reduce long-term and repeated psychiatric hospitalization by delivering intensive care designed to help stabilize a youth, provide for immediate treatment needs, and quickly return youth to their prior care setting in less than six months to continue their course of treatment. As such, they are an integral part of the OhioRISE home and community-based continuum of care. Offering PRTF in Ohio ensures that youth in these settings remain close to their families/guardians/caregivers when receiving medically necessary services, and families/guardians/caregivers (and others on the CFT) can remain connected, participate in, and inform the treatment as needed. ODM and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) have partnered with state system partners, Aetna, and stakeholders to develop standards that are included in this manual. Ohio final rules regarding PRTF can be found in Chapters [5122-41](https://codes.ohio.gov/ohio-administrative-code/chapter-5122-41) and [5160-59](https://codes.ohio.gov/ohio-administrative-code/chapter-5160-59) of the OAC.

PRTFs provide active, trauma-informed treatment at an inpatient level of care in the community under the direction of a physician, seven days per week, 24 hours per day, to youth under age 21 with complex mental health needs and their families, based on medical necessity as determined by the OhioRISE plan. A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. The key elements of a trauma-informed approach are:

- (1) realizing the prevalence of trauma;

- (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
- (3) responding by putting this knowledge into practice; and
- (4) avoiding re-traumatization.

PRTF is a specialized treatment service that supports youth with chronic behavioral health needs that would not be addressed in an acute psychiatric hospital stay meant to stabilize a mental health crisis. PRTF includes daily active treatment, achieved through a combination of family/guardian/caregiver, group, and individual therapy adapted to meet the individual needs and capabilities of the youth, consultation, and treatment planning with a comprehensive team of medical and behavioral health staff, in a highly structured living environment that accommodates the individual needs of the youth.

Transition planning begins at the time of admission to aid in a successful return to home, school and community within six months. Comprehensive transition planning is done with the OhioRISE care coordinator (from an OhioRISE CME or Aetna) working with the youth's CFT. More information regarding the Child and Family Team process can be found in the CME Manual located on the [OhioRISE Care Management Entities](#) page. In addition, PRTF staff are expected to participate on a youth's CFT for the duration of the youth's treatment at the PRTF and be available to the CFT for at least six months post-transition to the community.

PRTFs engage youth and their families/guardians/caregivers in a strength based and compassionate manner that is sensitive to cultural and linguistic differences to facilitate feelings of safety and comfort, identify and address behavioral health challenges, and stabilize symptoms through the utilization of evidence-based practices to prepare youth for a less restrictive environment.

Through a comprehensive and collaborative individual plan of care that outlines short-term treatment goals, while actively pursuing plans for long-term stabilization at home or in an alternate living situation, the PRTF collaborates with the CME through CFT meetings at the time of engagement with PRTF and ongoing throughout the episode of care, including transition from PRTF.

It is expected that the appropriate PRTF staff will be actively involved with the youth's CFT throughout treatment and will encourage and maintain care coordination involvement throughout treatment in order to promote successful transitions throughout treatment. This will be determined throughout the youth and family teaming process, where PRTF staff will be active participants.

Upon initial admission to PRTF treatment, CFT members and PRTF staff will meet at a minimum, every 30 days, and more often if it is determined needed by either the PRTF staff or members of the CFT. When youth is within 60 days of transition, CFT members and PRTF staff will meet at least three times within each 30-day period up until transition (or more if needed) for planning

successful transition back into the community. After a youth transitions back to the community, PRTF staff will be available to the CFT for consultation for at least six months.

The PRTF provider provides a consistent and predictable environment with intensive support and supervision in which there is a demonstrative understanding of the explicit and/or implicit trauma the youth may have experienced; delivers evidenced based and informed interventions to stabilize a youth and provide quality treatment to support a youth's rapid return home, and interventions that are reflective of Ohio's commitment to reduce seclusion and restraint. The PRTF provider demonstrates the ability to successfully engage youth and families/guardians/caregivers in PRTF services, and responsiveness to youth and family/guardian/caregiver voice.

Interventions offered by PRTFs are time limited and aimed at stabilizing a youth's identified behaviors and needs, while addressing the underlying etiology of these behaviors and needs so that the youth may safely return home with as little disruption to their life as possible. A core component of PRTF is engaging with the family/guardian/caregiver, supporting the family/guardian/caregiver to understand their youth's behavioral health needs, and to share strategies to address their youth's behavioral health needs. The goal of PRTFs is to facilitate the youth's reintegration into the family/guardian/caregiver and community or preparing for independent living. PRTFs is one of the OhioRISE Program's most restrictive interventions and thus should only be accessed when it is determined that all other therapeutic interventions will not safely or adequately address the youth's behavioral health needs.

PRTF is part of the home and community-based continuum of services, and one component of a robust system of care. The PRTF strives to minimize the time a youth is away from their family/guardian/caregiver and works to successfully provide this treatment in one episode per youth. There may be instances when a youth with intensive behavioral health needs that meet PRTF criteria have limited family/guardian support or no viable family/guardian/caregiver options at the time of admission. In these instances, the CFT will provide a developing/progressing permanency plan for the youth that includes securing a family/caregiver/home-like setting for the youth to be incorporated into the ongoing transition planning process.

Given the focused clinical nature of PRTF, it is not designed to be used in lieu of legal consequences or to rehabilitate criminogenic behavior. However, certain criminal charges should not prohibit a youth from PRTF treatment when the youth otherwise meets the medical necessity criteria for PRTF treatment.

Section 4: Youth Who May Benefit from PRTF

The OhioRISE program includes a broad array of services to support the needs of youth with behavioral health, substance use, and a dual diagnosis of mental illness and an intellectual or

developmental disability (MI/ID). Individuals referred to PRTF programs are young people under age 21 with complex needs, including significant behavioral challenges. These individuals have a mental health diagnosis or co-occurring mental health and other diagnosis, e.g., substance use, intellectual disability, and cannot be maintained in a community setting with a reasonable degree of safety. The youth approved for these programs require exceptional care on a 24/7 basis in an environment with intensive psychiatric clinical monitoring, medication management, and a concentrated individualized treatment protocol.

Many youth referred to a PRTF will have experienced trauma. Trauma is defined as the experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and /or the witnessing of violence, terrorism, or disasters.

Adverse Childhood Events (ACEs) have serious mental health consequences, and youth often learn to deal with them by adopting negative coping mechanisms (Felitti et al. 1998). Trauma-informed care therapeutic models are essential in understanding the impact of a youth's exposure to past and current traumatic events (Bloom, S.L., 1994). Youth identified for PRTF require continued intensive psychiatric care in a highly staffed and supportive residential milieu before they can return home or transition to a less intensive out-of-home treatment setting.

Individuals who may receive treatment in a PRTF that specializes in providing treatment for individuals with co-occurring MI/ID include youth with traumatic brain injuries, neurocognitive disorders, and other cognitive deficits, regardless of their etiology.

Section 5: PRTF Service Definition

What is a PRTF?

A PRTF is an inpatient level, intensive multi-disciplinary residential treatment provided in a non-hospital setting for young people with complex needs. A PRTF delivers trauma-informed, evidence-based, and individualized services to young people and their families/guardians/caregivers under direction of a physician in order to stabilize behaviors in as short as possible time frame to help young people and their families/guardians/caregivers develop the knowledge and skills needed to safely manage the youth's needs in the community, so that the young person can succeed in all aspects of community living, e.g., home and family, school, employment, etc.

PRTF services:

- Are nurturing, warm, engaging, therapeutic environments that meet the developmental needs of the youth served.
- Are delivered by supportive staff and in a peer culture that encourages support and acceptance, and celebrates growth and success

- Demonstrate that wellness, recovery, and self-determination are possible and recognize the positive potential inherent in all youth and their families/guardians/caregivers.
- Are strength-based and individualized to each person, with the goals established, quantity and frequency of services adjusted based upon the needs and strengths of individuals. As such, PRTFs do not use coercive practices, phases or level systems.
- Are trauma-informed, recognizing that youth who experience trauma, need trauma-informed approaches.
- Are time limited with lengths of stay generally within six months or less, with treatment focused on the objectives that are most important for the young person to address to achieve a successful transition to the community.
- Are able to address the intensive treatment, supervision, and safety needs of the young person referred.
- Possess the capacity and expertise to provide targeted treatment services to address the variety of needs of each young person.
- Are family/guardian/caregiver-driven, able to actively engage the families/guardians/caregivers, support the families/guardians/caregivers to understand their youth's behavioral health needs, and to engage the families/guardians/caregivers to learn strategies to address their youth's behavioral health needs from admission of the youth throughout the duration of PRTF treatment.
- Are inclusive of up-to-date knowledge and evidence-based treatment services that focus on the strengths of the young person and their family/caregiver.
- Are provided in a non-acute home-like environment (as discussed later in this section).
- Are culturally and linguistically competent, demonstrating commitment to equity, diversity, and inclusivity.

The PRTF for individuals with co-occurring MI/ID needs will be staffed with direct care staff trained to provide care for persons with MI/ID; the staff will be provided MI/ID specific training by DODD and OhioMHAS, as noted in [Appendix E](#). Staffing ratios will be individual-specific and circumstance-based. PRTFs for youth with MI/ID will address communication challenges with adapted communication and interviewing techniques as well as adapted crisis management and de-escalation techniques.

PRTF Service Components

The PRTF service is comprised of multiple components:

Initial Youth and Family/Guardian/Caregiver Introduction to PRTF Treatment Services

There are three steps related to engagement to consider when a youth prepares to enter treatment in a PRTF. It is important to always recognize that a new environment can feel very unpredictable and may create anxiety for a youth. They are being transitioned out of their community, family, and home to a place they have never been before, so it is important to give them as much up-front knowledge and familiarity with their treatment services and location as possible.

1. The first step to engagement involves the PRTF provider speaking with the youth and the family/guardian/caregiver about the PRTF: what it is, what treatment services will be provided, what to expect while the youth is there, how often they will be able to speak with family/guardian/caregiver, the purpose of the PRTF stay and general amount of time at the location. The PRTF staff will also provide an opportunity for the youth and family/guardian/caregiver to ask any questions they may have about the PRTF. This initial engagement should provide the youth and family to evidence the supportive and nurturing culture of the PRTF environment and should occur within 48 hours of the PRTF receiving the referral from Aetna.
2. The second step involves the youth and family/guardian/caregiver taking a tour of the facility and meeting some of the staff they will be working with on site. They will be able to see what their room will look like, where they will sleep, where they will have breakfast, lunch and dinner, and staff will give a general description of a “day in the life” at the PRTF. The staff will share with the youth and family/guardian/caregiver when they will be able to visit one another and talk to each other during the week and on weekends. The youth and family/guardian/caregiver will be able to ask questions about the PRTF. This will provide an opportunity for the youth and family/guardian/caregiver to experience the culture of the environment where they will be receiving treatment services. Individual youth and family circumstances should be considered when scheduling tours. Admission should not be delayed if a tour cannot be scheduled timely or if an individual youth’s circumstances indicate a tour is not feasible.
3. Finally, the youth and family will come to the facility for admission. Staff will show the youth to their room, introduce them to their roommate (if they have one) show them where to keep their things, give them a schedule for the week so they understand what they can expect to happen in the first few days of being in the PRTF (safety and predictability), go over PRTF-specific policies and procedures (to include restraint and seclusion policies) shares contact information for Disability Rights Ohio, and allow them some time with family/guardian/caregiver before they leave and the youth’s treatment begins. It is suggested that youth and family/guardian/caregiver leave one another with a plan for their next interaction (via phone call/visit/letter). The staff, youth and family/guardian/caregiver

will work together to create a safe environment, that takes into consideration the youth's history of trauma and behavioral health needs as they begin this path of treatment collaboratively.

Admissions

The following activities occur upon or shortly after admission:

- A **physical health examination** by a physician or advanced practice registered nurse is required for all youth not later than twenty-four hours after admission, to include an expanded laboratory (bloodwork) panel and other diagnostics.
 - At times, youth with MI/ID will present with decreased self-report and low threshold for other objective data to rule out undiagnosed medical conditions. Personal Protective Equipment will be carefully considered as persons with MI/ID are at increased risk of COVID-19 and other infectious diseases due to potential decreased self-report of symptoms (resulting in delayed diagnosis), as well as vulnerability to pulmonary and central nervous system conditions.
- A **psychiatric evaluation** by a psychiatrist or other qualified physician not later than forty-eight hours after admission. The evaluation may be conducted virtually as needed. For youth with intellectual disabilities, the evaluation should be performed by a psychiatrist with training or experience in intellectual disability.
- A **strengths-based bio-psychosocial assessment** will be completed for all youth. For youth with MI/ID, the developmental stage of the youth (mild, moderate, or severe intellectual disability) will be considered and integrated into a bio-psychosocial-developmental assessment and plan.
- An **individual plan of care**, developed with the family/guardian/caregiver and youth within 14 days of admission, describing measurable goals that the youth and family/guardian/caregiver want to attain, the interventions, and how progress towards the goals will be monitored with a focus on addressing the issues that are leading to the need for behavioral health services within a PRTF setting. These Targeted Treatment Goals (TTGs) will be initially identified by the Child and Family Team prior to the youth admitting to PRTF and refined by the PRTF. These TTGs will also inform the concurrent clinical reviews that will be conducted by Aetna while the member is being treated at the PRTF.
- An **individualized approach to safety planning and crisis response** will be incorporated for youth in PRTF settings. It should incorporate details of previous crisis and safety plans developed by the youth's CFT if one already exists for the youth and when appropriate. Since the PRTF is a highly structured setting, youth will be informed upon admission of rules within the setting to maintain safety for everyone. Youth will have

opportunities to develop a crisis and safety plan with their clinical team and PRTF staff collaboratively while they are staying in the PRTF setting. Specific crisis and safety plans will be created collaboratively with PRTF staff, youth, and parent/guardian/caregivers if a youth temporarily leaves the treatment facility for a family visit or community outing.

Treatment

The following services are included as part of PRTF treatment plans and tailored for individual youth needs:

- Psychiatric assessment and consultation (including input into the clinical component of an individual plan of care).
 - For youth with intellectual disability, psychiatric consultation will be available by psychiatrists with training or expertise in MI/ID. The consultation may involve a collateral data source for those youth with limited expressive language skills. DODD can facilitate linkage with resources if needed.
- Age and developmentally appropriate individual, group and family/guardian/caregiver therapy as described in the youth's individual plan of care.
- Weekly face-to-face consultation and psychiatric services when clinically indicated. Psychiatric services must be available at all times on site, telehealth, or by telephone, including routine and emergency psychiatric evaluations, medication evaluations, and prescription adjustments.
- Medication monitoring and education.
- Nursing services.
- Case management in collaboration with the youth's OhioRISE care coordinator or other entity leading care coordination for the youth.
- Independent daily living skills (Includes, but not limited to, Money Management, Socialization and Relationship Building, Meal Preparation, Interview Skills, Resume Building, etc.).
- Access and connection to other services such as:
 - psychological testing
 - vocational counseling
 - medical services to include vision and dental screening, as needed
 - Individualized therapeutic ancillary support materials and/or therapeutic support devices
 - sensory informed OT evaluation and communication evaluation for youth with MI/ID.

Other Services

- Education services that meet the minimum standards prescribed by the state board of education, whether through a public school, community school, or chartered nonpublic (private) school operated by or at the PRTF.
 - The PRTF must coordinate education services with the young person's school district when applicable.
 - All youth, including those with MI/ID will receive educational services according to their individualized educational plan.
- Art and music therapies as well as other ancillary services and organized recreational activities to support normative developmental experiences, i.e., outdoor play, relaxation, interests.
 - Youth with MI/ID will be offered recreational services that accommodate their individual medical, neurological and physical needs and capabilities.
- Transportation to other medical services, including laboratory, dental, vision, physical therapy, occupational therapy, or speech therapy, which the PRTF may provide directly or through coordination with the youth’s Medicaid MCO.

Throughout Service Delivery

Regular, active, and ongoing family/guardian/caregiver engagement will be maintained in all aspects of the PRTF service, including family/guardian/caregiver coordination, communication with staff, as well as regular and consistent contact with their youth via face-to-face family time, phone/video calls, normative family/guardian/caregiver activities at the PRTF location, and opportunities for family/guardian/caregiver outings when clinically appropriate.

Coordinated case management and transition planning with the OhioRISE care coordinator begins at the time of admission, and participation in the youth’s CFT is crucial to facilitate rapid stabilization and return to the youth’s family, community or prepare for independent living.

Frequency of Services and Expected Timelines

While all treatment is individualized to the youth’s needs, and providers are expected to demonstrate unique plans addressing the specific needs of each youth and their families/guardians/caregivers, the PRTF is expected to maintain the following MINIMUM frequency and/or duration of service components described in the table below.

Table 1: Frequency and Duration of Service Components

Service Component*	Minimum Frequency	Minimum Total Duration
A face-to-face consultation with a psychiatrist, other qualified	Once a week	Fifteen minutes

physician, or a prescriber either under the direction of a physician or other practitioner with prescribing authority or practicing under a collaborative agreement		
Individual counseling sessions with a licensed clinician	Twice each week	Ninety minutes
Group counseling sessions with a licensed clinician	Five times each week	Five hours
Family/guardian/caregiver therapy or other family/guardian/caregiver interventions	At least once each week and in accordance with the young person's individual plan of care	In accordance with the young person's individual plan of care
Art and music therapeutic services	In accordance with the young person's individual plan of care	In accordance with the young person's individual plan of care
Medication administration, monitoring, and education	As prescribed	As prescribed
Substance use disorder treatment in accordance with the American society of Addiction Medicine (ASAM) criteria	When clinically indicated and included in the PRTF's admission criteria	When clinically indicated and included in the PRTF's admission criteria
Ancillary services based on the young person's clinical needs as indicated in the young person's individual plan of care	Daily	Two hours each day

**At least one therapeutic service specified in this table must be provided on site each day. Therapeutic services must be provided for at least eight hours each week.*

Table 2: Timelines for Delivering Required Service Components

Timelines for Delivering Required Components	
Within 24 hours of admission	<ul style="list-style-type: none"> • A physical health examination by a physician or advanced practice registered nurse. * • Initial treatment and crisis plans will be completed, and copies provided to the youth and family/guardian/caregiver. • A nursing assessment will be completed and incorporated into the initial treatment and crisis plans. • The youth and their family/guardian/caregiver will be oriented to the services and facility-specific policies and procedures. • All necessary consents, releases and family/caregiver/guardian acknowledgement of receipt of restraint and seclusion policies will be completed and filed.
Within 48 hours of admission	<ul style="list-style-type: none"> • A psychiatric assessment, report and recommendations will be completed. *
Within 72 hours of admission	<ul style="list-style-type: none"> • A Substance Abuse screen will be completed. • A comprehensive individual crisis plan that details youth identified triggers, helpful and unhelpful environmental responses and specific interventions for staff. • A treatment team meeting will be conducted and a comprehensive treatment and transition plan that integrates all of the treatment team's input, assessments, and recommendations will be completed. The individual plan of care shall contain clearly delineated goals and objectives with specified timelines and benchmarks for success, including a detailed description of the treatment goals that must be attained in order for the youth to be considered transition ready. • A Nutritional screening will be completed. • Educational programming will be arranged. • Referrals for medical, dental, neurological or other identified evaluations.
Within fourteen	<ul style="list-style-type: none"> • An individual plan of care will be developed and implemented

days of admission	
Each day	<ul style="list-style-type: none"> • Comprehensive and well-documented communication regarding significant events, youth behaviors, and other relevant information will be provided for each shift. • All youth will be properly supervised; staffing and ratios will be reinforced. • Supervision ratios must be maintained at all times, including during crisis situations. • Beginning and end of day meetings will be convened to monitor the emotional state of each youth. • Medication will be dispensed by the amount and frequency prescribed and monitored as needed. • Youth will be transported to medical appointments, family/guardian/caregiver family time, community outings, and any other off-site requisite activities as needed. • A licensed clinician will have face-to-face contact and “check-in” with each youth. • All youth will have access to any necessary individually accommodating services and therapeutic/ancillary supports that have been defined on the individual plan of care.
Each week	<ul style="list-style-type: none"> • Documented units of services by service components (i.e., individual, group, family/guardian/caregiver therapy, family/guardian/caregiver engagement, etc.) and the youth’s response to the provided services and supports.
At least every 30 days	<ul style="list-style-type: none"> • Review the individual plan of care to ensure service provision and update as needed

**A PRTF may accept an examination that was completed in the 72-hours prior to admission, but cannot require one to be completed as a condition of admission. The examinations must be reviewed by the interdisciplinary treatment team within the first 72 hours and incorporated into treatment planning.*

Transition Planning and Post-Transition

Transition planning, in coordination with the youth’s CFT, begins upon admission. CFT members and PRTF staff will meet at a minimum every 30 days, and more often if it is determined needed by either the PRTF staff or members of the CFT. When youth is within 60 days of transition, CFT members and PRTF staff will meet at least three times within each 30-day period up until

transition, or more if needed, to transfer skills and strategies, plan and connect with providers, schools, and/or employers for post-transition resources to support successful transition into the home, community, school, and workplace.

CFT / Care Coordinator and PRTF Transition Planning Guidelines	
Before 60 Days of Transition	CFT/CC + PRTF meeting 1 x per month
60 Days before Transition	CFT/CC + PRTF meeting = *3x per month
30 Days before Transition	CFT/CC + PRTF meeting = *3x per month

**CFT/CC will have discretion regarding how these meetings are used. For example, if they need to be used for coordinating services locally and then informing PRTF of progress via email/phone/or CFT that may be documented as appropriate transition planning care coordination activities in collaboration with the PRTF.*

While preparing for, during, and after the transition from PRTF services, the CFCP developed by the CFT will delineate roles, services, and supports to be delivered by the PRTF and other providers. When planning for the transition from PRTF services is taking place as outlined above, the PRTF is expected to accommodate opportunities for external in-home and community-based providers to meet with the youth and family to facilitate the transition. As driven by the CFT process, it may be appropriate for external providers to hold individual and/or family therapy sessions with the young person and/or their family while they are still receiving PRTF services.

PRTF staff will remain available for consultation to the youth, family/guardian/caregiver, and CFT for at least six months-post transition from PRTF services to participate in CFT meetings and be available to the youth and family/guardian/caregiver to reinforce skills and strategies learned during PRTF, as well as collaborate on transition needs as the youth returns home.

Criteria for PRTF Providers Contracted to Serve Youth with MI/ID

If necessary, youth with intellectual disability may be evaluated using telemedicine (or a psychiatrist with expertise in MI/ID may provide consultation to the treating physician upon request of PRTF medical staff). Referral to the DODD cross-system behavioral health and support team should be made to determine the appropriateness of a referral to the Multi-Disciplinary Comprehensive Assessment Team and Regional Family Coach. Consultation with OCALI for an environmental review should be completed. DODD can arrange linkage to these resources.

Consultation with the psychiatrist should allow for more frequent and longer appointments to accommodate communication challenges, including limitations in expressive language skills.

- Individual counseling sessions using adapted techniques for MI/ID for at least 90 minutes weekly; persons with MI/ID may require shorter length and more frequent sessions due to memory and attention span difficulties
- Group therapy adapted for youth with MI/ID
- Medication administration (including de-prescribing as indicated), substance use treatment and family/guardian/caregiver therapy will be adapted for MI/ID
- Sensory evaluation, Sensory OT, PT, BCBA, and Behavior Support Specialist will have knowledge of MI/ID. The treatment plan will include a Behavior Support Specialists, as well as alternative treatments such as music, art, and recreation
- In general, the length of stay for treatment effectiveness in both inpatient and outpatient settings for persons with MI/ID is longer due to time to acclimate and time to understand/retain new principles and new coping skills
- Individualized service plans for MI/ID should consider the use of technology to increase independence, autonomy, and quality of life for youth with ID; they should also combine the philosophy of MH (recovery) with the philosophy of ID (self-determination)
- Environmental modifications such as paint color, lighting, auditory adaptations, and furniture to address the needs for youth with MI/ID will be available. There will be separate wings/units/cottages based on gender
- As with all PRTFs in Ohio, there will be a no eject/reject policy for those PRTFs serving youth with MI/ID that includes a comprehensive team evaluation of the youth including a bio-psycho-social-developmental formulation to inform clinical decision-making

Treatment Environment

Treatment Environment

While PRTF is very structured and is the most intensive supervised treatment setting, it remains important that each youth can partake in normal age-appropriate activities and that normal age-appropriate activities are not needlessly restricted. This includes supporting frequent contact via phone and visitation with family/guardian/caregiver or other supports. It is expected that the PRTF provider will support regular, consistent contact between the youth and their family/guardian/caregiver, unless otherwise indicated by court order or a legal guardian. The youth will be able to have contact with the family/guardian/caregiver regularly, including telephone calls, emails, letters, and face to face family time according to written policies established by the provider, and family/guardian/caregiver interactions will not be withheld due to behavior or used as part a reward.

Expectations for all youth receiving PRTF treatment:

- Required family/guardian/caregiver participation and coaching to translate knowledge and teach strategies and tools to be implemented in the home/next environment.

- Required local team participation in youth and family/guardian/caregiver meetings throughout the course of care, including transition planning meetings.
- The PRTF will provide support to youth transitioning back into the community through aftercare consultation with the care coordinator and child and family team.
- Teaching and coaching may occur at the PRTF facility or off-site, as dictated by the needs of the individual and capacity of provider. Teaching and coaching will occur while the youth resides at the PRTF and during the six-month post transition period.

Age Range Considerations for youth in PRTF

Age ranges consist of 6 to 12; 13 to 17; or 18 to 21. Youth will not be placed in the same unit/cottage that exceed age ranges more than three years apart. Special consideration will be given to youth whose age is outside of these age ranges but have treatment needs consistent with the PRTF service needs. Additionally, considerations will be made for developmental vs. chronological age when appropriate. Size and behaviors of youth may also be considered for unit placement. Further considerations may be made based on size of unit. Age should be considered as it relates to appropriate therapeutic milieu and developmentally appropriate sleeping arrangements.

Trauma-Informed Treatment

PRTFs provide trauma-informed active treatment at an inpatient level of care in the community under the direction of a physician, seven days per week, 24 hours per day, to youth under age 21 with complex mental health needs and their families/guardians/caregivers. The treatment should incorporate Substance Abuse and Mental Health Services Administration's (SAMHSA's) key principles of trauma-informed care:

- Safety.
- Trustworthiness and transparency.
- Peer support, e.g., development of a youth and/or family/guardian/caregiver peer mentor program, peer council, etc.
- Collaboration and mutuality.
- Empowerment, voice, and choice.
- Cultural, historical, and gender issues.

Additionally, the treatment should incorporate the following trauma-informed practices:

- Reduces and avoids re-traumatization that can occur in a residential treatment environment.
- Provides a therapeutic setting where all staff understand the impact of trauma on young people and their development, and staff interaction with youth reflects trauma-informed practice.

- Is nurturing, non-coercive, family-friendly, and provides for normalcy and consistency. The PRTF does not use punitive systems, e.g., a level system or a “token economy” where a young person may lose an earned level.
- PRTF staff will reinforce youth strengths as levers to reinforce positive behaviors and encourage an environment where all youth and staff focus on celebrating accomplishments.
- Focuses on assisting young people with self-regulation.
- Staff identify trauma-informed strategies around safety as part of engagement, including developing comfort plans for each young person, as well as incorporating other strategies and tools such as making available the use of sensory items for a young person. A comfort plan is an individualized plan that is established by the youth and staff and includes youth’s personal triggers, warning signs and comfort measures that help the youth calm and self-soothe during periods of distress. Comfort plans do not reflect any punitive measures or consequences.
- Staff recognize crisis triggers during treatment, assist the young person if needed with implementing individual comfort plans and engage with the young person to prevent the escalation of behaviors.
- The trauma-informed services that the youth receives while at PRTF promote the use of more adaptive coping strategies to encourage resilience and improved function. Treatment at PRTF is not designed or intended for youth “process” all their trauma.

Young Person and Family Engagement

PRTF is a youth and family/guardian/caregiver driven service. The young person and their family/guardian/caregiver are viewed as full participants in the treatment team, and their needs, preferences, and choices are valued and respected.

The PRTF shall orient the family/guardian/caregiver and youth to the PRTF service and provide the family/guardian/caregiver clear communication and explanations related to the young person’s service needs at a frequency defined by the young person and their family/guardian/caregiver and/or care plan.

The young person shall be asked directly for their input on and offered choices in their treatment services, as their input and choices are respected and incorporated into the individual plan of care whenever clinically and developmentally appropriate.

The PRTF actively engages the family/guardian/caregiver in partnership with the OhioRISE care coordinator (or other entity leading care coordination for the youth) and the CFT. The family/guardian/caregiver is invited to participate in PRTF's treatment team meetings, which are held at times convenient to the family/guardian/caregiver. Families/guardians/caregivers are encouraged to be full participants in the youth’s ongoing care including participation in

clinical appointments. The family/guardian/caregiver is invited to participate in family/guardian/caregiver counseling from the time of the young person's admission. The PRTF will provide additional family/guardian/caregiver services and supports or, via the OhioRISE care coordinator (or other entity leading care coordination for the youth) refer the family/guardian/caregiver for recommended individualized services and supports in the community, e.g., individual therapy, parenting classes, parent mentors or peer supports, parenting self-care information, etc.

PRTF makes available and utilizes technology for visitation, clinical services, and treatment team meetings. Additionally, the PRTF will identify and create individualized opportunities for family/guardian/caregiver involvement when needed to support engagement.

Assessment

A cross-discipline bio-psychosocial assessment addressing psychiatric, nursing, and clinical issues will include the youth and family's/guardian's/caregiver's strengths and needs that will inform the individual plan of care. Assessment will either incorporate the most recent CANS information, or the PRTF provider will work with the OhioRISE care coordinator (or other entity leading care coordination for the youth) to update the CANS to reflect new information, as indicated.

CANS assessments are to continue to be completed at a minimum of every 90 days or whenever there is a significant change in the youth's behavioral health needs or circumstances. The PRTF will coordinate necessary CANS assessments with the OhioRISE care coordinator, and if the OhioRISE care coordinator is unable to perform the CANS assessment, certified staff at the PRTF may render and submit the CANS assessment. At a minimum, the family/guardian/caregiver, youth, treatment team including the clinician, education staff, and others as recommended in the CANS reference guide available at www.cansohio.org are to be contacted and their input included in the assessment process. Attempts to include involved parties are to be documented. Since CANS is a consensus-based tool, CANS assessments should incorporate appropriate perspectives, and CANS assessors should engage in consensus ratings for initial and subsequent CANS updates.

Individual Plan of Care

The PRTF program will develop individualized plans of care with a multi-disciplinary team that includes the youth, family/guardian/caregiver, clinicians, milieu staff and psychiatric care providers. The individualized integrated plan of care will include referrals for medical, dental, neurological or other identified evaluations, as well as identify strengths that will be built upon or leveraged to meet the youth and family's/guardian's/caregiver's stated goals.

The individual plan of care shall be in writing and developed for each young person to improve their condition to the extent that PRTF care is no longer necessary. The individual plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the young person's situation and reflects the need for PRTF care.
2. Be developed by a team of professionals specified in paragraph (D) of OAC rule [5122-41-07](#) in consultation with the young person and their family/guardian/caregiver.
3. State treatment objectives.
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives.
5. Incorporate the following three components:
 - a. Comfort plan – an individualized plan that is established by the youth and staff that includes the youth's personal triggers, warning signs and comfort measures that help the youth calm and self-soothe during periods of distress.
 - b. Safety plan – a plan developed for staff on how to positively approach a youth when a specific behavior begins to escalate. This plan will include strengths, needs, triggers, and detailed strategies that will be used with a particular focus on early recognition of triggers, de-escalation, and calming techniques. The safety plan may be implemented in an immediate and expedient manner to manage imminent safety issues by a unit staff member, treatment team member or clinical leadership when a youth's risk behaviors disrupt the milieu.
 - c. Behavior plan – plan for goals that the treatment team and the youth work on to control the youth's behavior.
6. The plan must be reviewed at least every thirty days, and more often when clinically indicated by the treatment team and the youth and family/guardian/caregiver to:
 - a. Determine those services being provided are or were required to be provided in the PRTF.
 - b. Recommend changes in the plan as indicated by the young person's overall progress in the PRTF.

Individualized Therapeutic Services

All PRTF services and interventions must be directly related to the goals and objectives established in each youth's individual plan of care. PRTF providers are expected to incorporate up-to-date clinical knowledge and evidenced based and evidenced-informed practices into service delivery.

It is anticipated that interventions would include, but not be limited to:

- Instruction in learning adaptive frustration tolerance and expression, which may include anger management
- Instruction in stress reduction techniques
- Problem solving skill development
- Psycho-educational services to improve decision making skills to manage behavior and reduce risk behaviors
- Social skills development
- Instruction in Activities of Daily Living
- Behavioral Support Plan as indicated
- Family/guardian/caregiver training and support for transition of the youth back home

Care Coordination, Transition Planning and Continuity of Care

Youth will have an OhioRISE care coordinator (CME or Aetna) and the PRTF provider is expected to participate in the youth's CFT team. The PRTF coordinates care with the CFT while anticipating transition into the PRTF for treatment, during treatment, as part of transition planning, and after treatment.

The PRTF provider will work closely with the CFT team to develop a transition plan that ensures successful integration into PRTF treatment, evolves to build upon the successes and strategies identified during the PRTF intervention, and helps the CFT Team to anticipate common challenges that can occur during transition to the home or community and collectively strategize on how to address. The PRTF provider will participate with the youth's CFT meetings that occur during the youth's tenure in a PRTF and post transition as requested by the CFT.

While the CFT Team and OhioRISE care coordinator will also have responsibilities to support the youth's transition to the community, it is the PRTF provider who begins transition planning within twenty-four hours of admission through active family/guardian/caregiver education and engagement in the care of young people and contact with the care coordinator to facilitate exchange of information.

The PRTF provider, as part of the CFT, will partner with the young person and family/guardian/caregiver to engage and utilize natural community supports as part of transition planning and establish individualized warm hand-offs with community providers or partners prior to the transition. The PRTF provides written documentation to all participants of the transition plan prior to the young person leaving the PRTF with information on how to access additional supports from the PRTF and community providers, including contact information and steps required to access each provider.

As part of treatment and transition planning, it is anticipated that many youth would benefit from therapeutic passes, allowing the youth and family/guardian/caregiver time outside of the

PRTF to engage in typical family/guardian/caregiver activities, practice strategies being learned in treatment, and support reintegration into the youth's family home, school and community. All use of therapeutic passes must be:

- Individualized to the particular treatment needs of each youth.
- Goal-directed, and clearly described in the individualized plan how therapeutic passes support the youth attaining their particular goals.
- Planned and no more than three-consecutive days at a time.
- Include a clear plan for the youth and family/guardian/caregiver in the event they need support from the PRTF during the therapeutic pass.
- Include a debrief with the youth and family/guardian/caregiver to reinforce successes, reinforce skill development, and adjust the plan as needed.

There may be some instances in which a youth receiving PRTF services requires other emergent medical services that the PRTF provider cannot provide. The PRTF provider will have a written transfer agreement in effect with one or more Ohio Medicaid participating hospitals that reasonably ensure that a child or youth will be transferred from the facility to the hospital and admitted in a timely manner when a transfer is medically necessary for medical or acute psychiatric care, in accordance with [42 CFR 483.372](#). In situations in which a youth may need overnight stays in a hospital, the PRTF will coordinate care with the medical provider and hold capacity to serve that youth upon their return.

There may be some instances in which a youth may need an overnight stay in an acute inpatient hospital for behavioral health reasons. This occurrence is expected to be infrequent and the PRTF is required to notify the OhioRISE plan and the family/guardian/caregiver of this leave event within twenty-four hours. While the PRTF is an inpatient level of care, it is also a non-hospital setting. Infrequent, though anticipated, instances when a PRTF recommends an acute hospital setting for a youth could provide immediate access to an inpatient behavioral health provider. The PRTF will coordinate care with the acute inpatient behavioral health provider and hold capacity to serve that youth upon their return for at least three consecutive days.

The PRTF is available to community partners, the young person, and their family/guardian/caregiver at least six months post transition when the young person is transitioned to a community setting, including at least monthly contact with the young person and family/guardian/caregiver, unless the provider documents that the young person and family/guardian/caregiver decline this contact when the PRTF discusses it and offers it as part of transition planning in conjunction with the CFT.

Education

PRTF providers are expected to facilitate the ongoing provision of an appropriate educational program as required under federal and state education law. Medicaid does not fund educational programs and services that youth are entitled to under those laws or provide on-site educational services for youth in out-of-home treatment settings. As such, the PRTF provider will be expected to provide for educational programming and services as described in the provider application as well as follow all federal and state education laws.

If the PRTF provider establishes that the local public school district in which the facility/(home) is situated will provide educational programming which includes IEP services, then the following must occur to ensure that educational programming is not disrupted:

- Creation of a Memorandum of Understanding between the facility/home and the district which details at a minimum the educational services, transportation, Education Management Information System (EMIS) data reporting and billing requirements,
- Establish communication protocols between the facility and the school the child will be attending,
- Establish protocols on parent/caregiver engagement,
- If the student came from an area different than the district providing education to the children in the facility, establish communication protocols with that district.

If the PRTF provider establishes a Contract for educational services with the local Educational Services Center (ESC) in which the facility/(home) is situated, then the following must occur to ensure that educational programming is not disrupted:

- Contract should include, at a minimum, the educational services, transportation, and communication protocols for EMIS data reporting with child's district of residence and billing requirements.
- If the student came from an area different than the district providing education to the children in the facility, establish communication protocols with that district.
- Establish protocols on parent/caregiver engagement.

If the PRTF provider establishes its own Public Charter or Community school, then the following must occur to ensure that educational programming is not disrupted:

- Follow all State and Federal Laws and regulations related to education and to the operation of a Public Charter or Community school,
- Establish Memorandum of Understanding with each child's district of residence to cover EMIS data reporting and billing,

- If the student came from an area different than the district providing education to the children in the facility, establish communication protocols with that district.
- Establish protocols on parent/caregiver engagement.

If the PRTF provider establishes its own Chartered Nonpublic school, then the following must occur to ensure that educational programming is not disrupted:

- Follow all State Laws and regulations related to education and to the operation of a chartered nonpublic school,
- Establish communication protocols between the facility and the school the child will be attending,
- If the student came from an area different than the district providing education to the children in the facility, establish communication protocols with that district.
- Establish protocols on parent/caregiver engagement.

Regardless of the way the PRTF provides for education, youth must have access to career-technical education. When attending the local public district and/or contracting for educational services, students can access career-technical education through the delivery method typically offered within the district. When operating as a public charter school, the PRTF may apply to have their own career-technical education programming or contract with another entity. When operating as a chartered nonpublic school, the PRTF may contract with another entity, or the student may directly enroll into career-technical education. For additional information regarding Career and Technical education please contact the general office inbox (CTE@education.ohio.gov).

Establishing communication protocols and processes for student transition should happen at the point of acceptance of a child into a PRTF. While planning these processes, consider the following: student records, Individualized Education Program (IEP) or Evaluation Team Reports, related services requirements, [graduation requirements](#) course completion and academic credits, demonstration of competency and demonstration of readiness and [requirements for students with an IEP](#) and who are 14 and older to engage in the transition goals as detailed in the IEP.

For children in Foster Care please reference [education guidance](#) established by Ohio Department of Education and Ohio Department of Jobs and Family Services.

In some situations, a child may be attending an educational scholarship program, either the Jon Peterson, Autism or the EdChoice scholarship. Due to the individual nature of each child and scholarship, it is best to contact the Ohio Department of Education Scholarship office to address

each on a case-by-case basis. Please contact either autismscholarship@education.ohio.gov or petererson.scholarship@education.ohio.gov.

All providers must commit to providing accurate documentation to the educational entity providing service to facilitate the educational process for students in their care.

In addition to access to school requirements noted above, the collaboration and coordination of services for children in the facility should consider also inviting education staff as part of the treatment team. Communication about productive treatment approaches and barriers among team members are aimed to support the therapeutic treatment which best supports a successful transition out of the facility with sustained stability across all aspects of the whole child, including education. Accordingly, genuine and proactive coordination and collaboration between the provider and educational professionals is expected.

PRTF providers shall ensure:

1. A balanced and coordinated effort between clinical treatment and educational programming and service delivery and a trauma-informed environment and approach to education;
2. Daily before and after school communication strategies with education staff;
3. Daily support of student homework, special projects, and study time;
4. Specific strategies, including responsible staff and timelines, for including families-of-origin and/or natural supports available to the child in educational programming and progress review;
5. Availability of computers for student use to support homework and projects;
6. Problem resolution strategies;
7. Immediate and therapeutic responses to problems that rise during the school day;
8. Supervision of students who are unable to attend school due to illness or suspension;
9. Shall ensure that the state compulsory education rule as well as meeting the minimum service minutes as written in the students' IEP goals;
10. Supervision of and programming for students who do not have a summer school or who have graduated high school as well as for breaks/vacation times;
11. Adequate supervision, programming, and professional staff contact in support of any educational work outside of school hours such as a student with independent work, online classes, homework and or projects.

12. For youth with intellectual disability, the PRTF will request consultation with OCALI as needed. Educational liaison between the onsite educational programming and the LEA/Local Team/Family will occur.

The possibility of a variety of situations may arise regarding connecting with a school district of the child’s residence and the school district providing educational services which may require additional support from an Education Area Coordinator. Please [use this directory to contact an Area Coordinator.](#)

Table 3: Matrix for OhioRISE PRTFs and Applicable Education Rules

Education Facility type Required Steps for Implementation	Public School district where the facility exists	Chartered Non-public school	Chartered public school / Community School	Educational Service Center, either on-site or alternate location	Public School District other than the district where the facility exists	Service from an online community school
Creation of an allowable and appropriate educational chartered public or non-chartered, nonpublic school	N/A	Identify and understand the process to become a chartered nonpublic school	N/A	N/A	N/A	N/A
Contract MOU with educational service provider	✓	✓ Either operated as PRTF or an already existing entity	✓ Either operated as PRTF or an already existing entity	✓	✓	✓
Student Accountability in EMIS	✓	Child’s school district of residence	✓	Child’s school district of residence	Child’s school district of residence	✓
Provision of Instructional and Support Services	✓	✓	✓	✓	✓	✓
Responsibility for conducting Evaluation Team Report (placement)	Yes- if child is parentally placed	Public School district where the facility exists	✓, unless the child’s parents will seek the Autism Scholarship, then the district of residence conducts.	Child’s school district of residence	Child’s school district of residence	✓

Responsibility for implementation of the IEP and related services. If parentally placed, then the educational facility type	✓	If parentally placed, special education services are based on an Individual Services Plan created by the public school district where the facility exists.	✓	✓	✓	✓
IEP Progress reporting as required	✓	✓	✓	✓	✓	✓
Transition of records	✓	✓	✓	✓	✓	✓
Transportation	✓	Public school district wherein the facility exists.	Public school district wherein the facility exists.	Public school district wherein the facility exists.	Public school district wherein the facility exists.	✓
Family involvement (IEP and Title 1)	✓	✓	✓	✓	✓	✓

If you have a situation not covered by the above table, please reach out to an [Area Coordinator](#).

Restraint, Seclusion and Time-Out

PRTFs must comply with the CMS Condition of Participation regulating the use of restraint and seclusion in [42 CFR § 483.350 – 483.376](#). As such, PRTFs are subject to Ohio Department of Health (ODH) and CMS surveys. A PRTF must further comply with restraint and seclusion rules [5122-26-16](#) and [5122-26-16.1](#) of the Administrative Code and the “Psychiatric Residential Treatment Facility (PRTF) Seclusion and Restraint” memo:



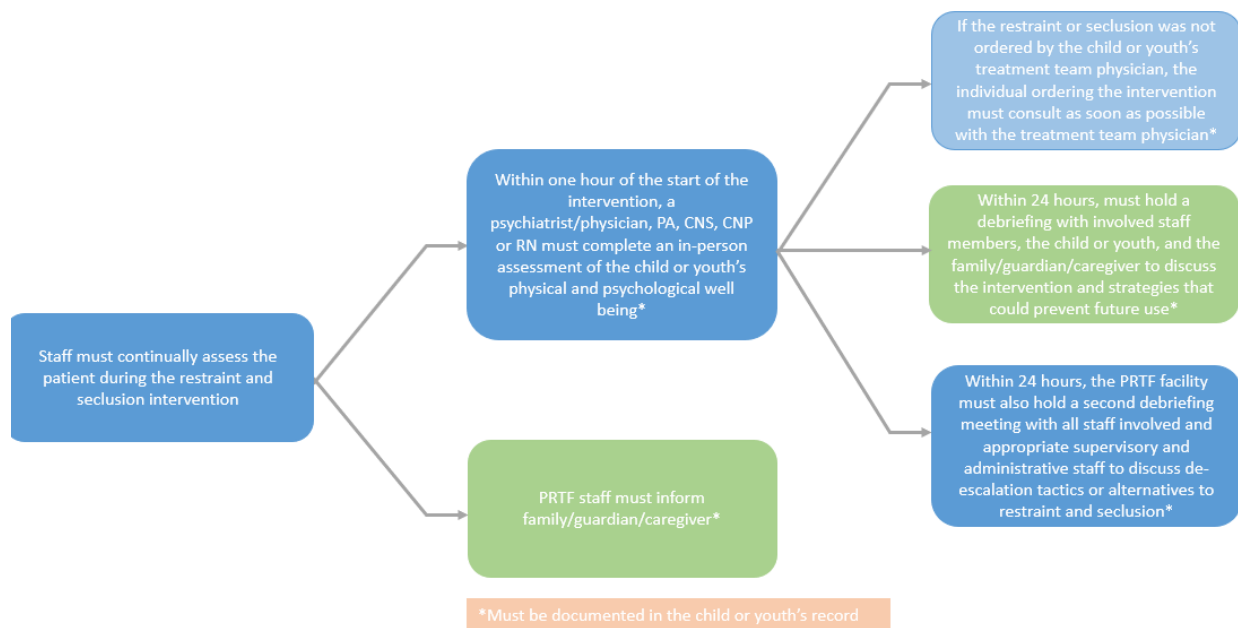
PRTF Seclusion and Restraint Memo 9.20

Restraint and seclusion can only be used in an emergency, not on an as needed or standing order basis. As such, drugs used as chemical restraints cannot be used on a PRN basis. PRTF providers must inform the youth and the family/guardian/caregiver of the restraint and seclusion policy, obtain written acknowledgement of restraint and seclusion policies and provide contact information for Disability Rights Ohio upon admission. All orders for restraint or seclusion must be made by the youth’s treatment team physician, when the team physician is

available. If the treatment team physician is not available, the physician’s assistant (PA), certified nurse practitioner (CNP), clinical nurse specialist (CNS), registered nurse (RN), licensed independent behavioral health practitioner (licensed psychologist, licensed independent social worker, licensed professional clinical counselor, licensed independent chemical dependency counselor or dependently licensed behavioral health practitioner under supervision) who is appropriately trained and authorized to order restraint or seclusion in accordance with his or her scope of practice and as permitted by applicable law or regulation. If the order for restraint or seclusion is placed by phone, the ordering provider must stay available via phone for the duration of the intervention. Within one hour of the initiation of the initiation of the seclusion or restraint, and immediately after the restraint or seclusion is removed, a physician, PA, CNS, CNP or RN must evaluate the youth’s well-being..

Use of seclusion or restraint entails documentation, monitoring, notification, and reporting requirements, as noted in the CFR and OAC regulations above. Thorough documentation about the emergency safety intervention must be included in the youth’s record, to include the signed order for restraint or seclusion, the time the emergency safety intervention began and ended, the time and results of the one hour assessment, the emergency safety situation that required the youth to be restrained or put in seclusion, the name of the staff involved in the emergency safety intervention, consultation with the treatment team physician, notification of the parent/guardian/custodian, detailed information about required debriefing sessions, injuries that resulted from the emergency safety intervention, and reporting of serious occurrences and/or deaths. Follow-up activities related to restraint or seclusion are depicted below.

Figure A: Follow-Up Requirements for Restraint and Seclusion



The facility's executive director, chief executive officer, president, or similar position must provide an attestation certifying it is compliant with CMS standards governing the use of restraint and seclusion. A copy of this attestation must be provided to ODM when enrolling as a PRTF provider, by July 21 each year, and at any time the individual with the legal authority to obligate the facility is no longer in such position. The required attestation form is in [Appendix A](#) of this document.

ODM, OhioMHAS and Aetna believe seclusion and restraint of youth are not treatment and are contrary to the mission of OhioRISE. A prevention-oriented philosophy is preferred consisting of progressive policy, regulations, forms, training and supervisory philosophy and milieu environment.

ODM, OhioMHAS and Aetna are committed to the reduction and ultimate elimination of the use of seclusion and restraints. [The Six Core Strategies for Reducing Seclusion and Restraint Use](#) is an evidence-based model developed by the National Association of State Mental Health Program Directors that has successfully reduced the use of seclusion and restraint in a variety of mental health settings for youth and adults across the United States and internationally. PRTF providers are expected to develop policies, procedures, training, supervisory, and quality oversight processes that address all six strategies and align with Ohio's goal to eliminate use of restraint and seclusion.

ODM, OhioMHAS, and Aetna are concerned with the management, treatment, and prevention of trauma that affects so many youth. Adopting trauma-informed treatment practices, creating calm surroundings and establishing positive, trusting relationships are essential to facilitating a youth's treatment. Youth who present with challenges requiring services should be understood in terms of their experiences of trauma and consequent difficulties in forming and maintaining healthy attachments. Trauma may affect youth in a multitude of ways, such as disruption in emotional responses, behavior, cognition, physical health, self-concept, and future orientation. Increased isolation and fewer social opportunities can contribute to low self-esteem and less opportunity to learn about abuse prevention. PRTF providers will develop policies, procedures, training, supervisory, and quality oversight processes that ensure a nurturing, trauma-informed treatment approach is delivered by all PRTF staff.

The goal of reducing and minimizing the use of seclusion and restraint is one that must be shared and articulated by the provider's leadership. The elevation of oversight by leadership of each use of seclusion or restraint to investigate causality, ascertain relevancy of current policies and procedures, and identify any associated workforce development issues, is core to the successful achievement of this goal.

Restraint or seclusion shall not be used unless it is in response to a crisis, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is possible. Restraint or seclusion shall be employed for the least amount of time necessary in order that the individual may resume their treatment as quickly as possible.

Seclusion and restraint are intrusive techniques to be used by trained, qualified staff as a last resort to control dangerous and potentially harmful behaviors and to preserve safety. Best practices include careful early assessment of a person's trauma history, experiences, preferences, and the effectiveness or ineffectiveness of past exposure to these methods. Best practices must be based on understanding and consideration of the individual's history of traumatic experiences to gain insight into origins and patterns of the individual's actions. A youth's behavior plan should first be implemented as a way to mitigate the potential for seclusion and restraint.

Use of seclusion or restraint must be subject to performance improvement processes to identify ways in which the use of these methods can be decreased or avoided, and more positive, relevant and less potentially dangerous techniques used in their place.

When individuals experience repeated or sustained use of these methods, leadership should evaluate all causative factors and consider alternative treatment interventions and possible transfer to a more structured treatment setting with the capacity to meet individual needs with reduced exposure to these intrusive interventions.

For youth with MI/ID, care providers must receive specialized training in the area of seclusion and restraints due to the multiple neurological, cardiac, and pulmonary needs of the MI/ID patient population to address the increased safety risks and potential limited verbal capabilities/self-report of the youth.

PRTF Building and Living Requirements

ODM, OhioMHAS, and Aetna are interested in building a PRTF network that offers an inpatient level of care that is provided in a non-acute home-like environment. PRTFs will:

- Be in either a separate, free-standing building or a building with other services, which may include a class one residential facility, but be located on a separate floor or in a separate unit or wing.
- Provide to each young person a single or double occupancy bedroom while meeting all other standards regarding sleeping space in rule [5122-30-14](#) of the Administrative Code.
- Respect as much as possible the young person's choice regarding services and supports, and who provides them.
- Respect the young person's choice of schedule and activities, and access to food as clinically appropriate.

- Allow the young person freedom to furnish and decorate their sleeping and living areas as much as possible while being consistent with considerations for the health and safety of the young persons.
- Meet the following for the living and dining space of the facility in addition to the standards in rule [5122-30-14](#) of the Administrative Code:
 - Have a meeting space that is large enough to accommodate all youth at the same time.
 - Have a communal area that provides space and opportunities for small group activities and socializing.
 - Have entertainment or recreational areas, including furnishings, that promote social engagement.

For youth with intellectual disabilities, building and living arrangements will abide by the requirements set forth by the Americans with Disabilities Act, which includes environmental modifications for paint color, lighting, auditory adaptations, and furniture.

Licensing

PRTF providers are required to be licensed as a PRTF and meet all standards pursuant to Chapters [5122-41](#) and [5122-30](#) of the Administrative Code except the qualified residential treatment program (QRTP) standards pursuant to [rule 5122-30-32](#) of the Administrative Code; document PRTF services in accordance with [Chapter 5122-27](#) of the Administrative Code; maintain compliance with applicable state and federal laws and regulation; hold and maintain other required licenses or certificates as applicable, e.g., school, dietary, etc.; and meet the federal emergency preparedness requirements of [42 C.F.R. 441.184](#), including testing the emergency plan twice per year.

PRTF State Survey Agency Requirements

State Survey Agency's (SA) are to assure that surveys are conducted in 20% of the PRTFs in the state annually to validate the accuracy of the attestations and investigate complaints. SA will ensure that PRTF CMS recertification surveys are conducted at least every five years for each certified PRTF. SAs will enter all PRTF attestations and provider agreements received from the State Medicaid Agency into the ASPEN system upon receipt. Complaints triaged at the Immediate Jeopardy level will be investigated within two days. All surveys are unannounced.

The conditions of participation for PRTFs are contained in [42 CFR Part 483, Subpart G](#): Condition of Participation for the Use of Restraint or Seclusion in PRTFs providing inpatient psychiatric Services for individuals under 21 years of age.

Survey Process will include the following:

- Entrance Conference with facility administration
- Required Information will be presented at that time

- Task 1: Representative sample of residents is identified by survey team
- Task 2: Record review of individual residents in the sample
- Task 3: Review of other records
 - Death records
 - Complaints
 - Policies and Procedures
 - Serious injury and occurrences reports
- Task 4: Resident observations
- Task 5: Interviews
 - Staff
 - Residents
 - Parents and legal guardians
 - Department heads and facility administration
- Task 6: Visit to each area of the facility serving residents
 - Kitchen
 - Bathrooms
 - Common rooms
- Task 7: Compliance Determination and preparations are made for the exit conference
- Task 8: Hold the exit conference with the facility administration

More detailed information can be located within Chapter 2 of the Centers for Medicare and Medicaid Services State Operations Manual (SOM).

Section 6: Staffing

The PRTF will maintain a staff hiring and on-going staff development system (which may include training by entities external to the PRTF) to assure staff have sufficient competencies to address the needs of the young people described in the PRTF's admission criteria.

Required Staffing

PRTF staff shall include:

- Physician medical director. If the medical director is not a board-certified or board-eligible psychiatrist, the PRTF shall also employ or contract with a psychiatrist who meets this qualification.
- Administrative director, who shall meet one of the following qualifications:
 - Master's degree in human services field plus two years prior human services supervisory experience.
 - Bachelor's degree in human services field plus four years prior human services program supervisory experience.
- Clinical director who is trained in an evidence-based trauma treatment/intervention model with two years clinical experience in a mental health setting that served youth or adolescents with emotional problems.

- The clinical director may also serve as the administrative director.
 - The physician medical director may also serve as the clinical director if employed at least forty hours/week.
- Sufficient clinical staff to meet each resident's treatment needs and who are appropriately credentialed to provide mental health services. If the PRTF provides services to young people with co-occurring substance use disorders, sufficient clinical staff shall be credentialed to provide substance use disorder treatment. If the PRTF provides services to youth with MI/ID, the PRTF will have sufficient clinical staff with expertise in treatment for youth with intellectual and developmental disabilities.
- Sufficient direct care staff, which may include clinical and nursing staff, to meet all residents' supervisory and care needs.
 - During the hours of eight a.m. until ten p.m., PRTF maintains a staffing ratio of at least one direct care staff for each three residents. The PRTF will have a minimum of two direct care staff at all times, including a practitioner with a scope of practice of at least a registered nurse.
 - During the hours of ten p.m. until eight a.m., the PRTF maintains a staffing ratio of at least one direct care staff for each six residents. The PRTF will have a minimum of two direct care staff at all times, including a practitioner with a scope of practice of at least a licensed practical nurse.
- The PRTF includes additional staff as needed to meet resident's dietary, educational, social, recreational, cultural, and other needs.
- When PRTF staff are on duty, they are dedicated to the PRTF service. If there is another residential or outpatient services facility on the grounds where the PRTF is located, when direct care and nursing staff are on-duty in the PRTF, these staff are specifically assigned to the PRTF with duties separate from other services, e.g., acute, other residential or outpatient services.
- The PRTF increases staff when necessary to meet the acuity needs of the young person. The PRTF provider will develop a plan to demonstrate how it will provide this flexible staffing.
- The following staff shall be on call at all times and available to come on-site to the PRTF when one is not available on-site:
 - Psychiatrist, Doctorate level behavioral health professional, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician with behavioral health experience. If the staff person available to come on-site is not a psychiatrist, a psychiatrist shall be on call.

- Licensed clinician. With the exception of a certified nurse practitioner, this does not include staff who are registered or certified by an Ohio licensing board, e.g., a registered social work assistant or certified chemical dependency counselor assistant.

Psychiatrists providing treatment for youth with MI/ID should have training or experience with MI/ID patient population. Direct care staff serving youth in the PRTF for youth with MI/ID will have received additional training for meeting the needs of individuals with developmental disabilities, as noted in [Appendix E](#).

Turnover rates impact quality of services provided. Outcomes for youth are improved where there is staff retention. Competitive compensation for employees is more likely to attract seasoned applicants and maintain a consistent, highly qualified, and experienced team. It is imperative that providers of out-of-home treatment services create a structural business framework in which turnover is minimized, particularly of direct care/milieu staff. This includes adequate support and supervision, training, incentives, and competitive salary offerings.

Section 7: Pathway to PRTF

PRTF is a Medicaid service. Youth who are eligible for Ohio Medicaid and need a PRTF intensity of service will meet the criteria for OhioRISE enrollment, so all referrals for PRTF services will be submitted to the OhioRISE plan, Aetna Better Health of Ohio. Available clinical services and community supports, that would allow a youth to safely remain in a less restrictive environment, should be considered prior to a PRTF intervention. OhioRISE Care Coordinators, in collaboration with a youth's CFT, must engage the support of their CME's clinical hierarchy as they explore less restrictive options. The CME's clinical hierarchy has access to Aetna and state partners for additional technical assistance. When clinical services and community supports have been given complete consideration and have been determined to be unable to meet the youth's treatment needs based on current presentation and functioning. The PRTF recommendation should be noted on the youth's CFCP and the OhioRISE care coordinator will submit the PRTF Request Form ([Appendix C](#)) and accompanying documentation to Aetna via the FamilyCare Central portal. The required submission must include acknowledgement that the youth's treating and/or CME psychiatrist support the referral for PRTF intensity of service. The OhioRISE care coordinator may be from an OhioRISE CME or Aetna, depending on tier assignment.

Youth enrolled in OhioRISE who are receiving care coordination through an entity other than Aetna or a CME for whom PRTF service is being sought, the care coordination entity will contact the assigned Aetna Tier 1 care coordinator, or if they need assistance identifying that person, call Aetna at 833-711-0773 (M-F 7am-8pm EST). Aetna will assign an Aetna care coordinator to work with the care coordination entity to complete and submit the PRTF Request Form.

Medicaid eligible youth who are not yet enrolled in the OhioRISE plan who may be in need of PRTF services will contact the Medicaid MCO or the OhioRISE plan to request a CANS assessment to assess needs and initiate OhioRISE enrollment.

For youth who have a behavioral health inpatient hospitalization that results in the youth's first connection to OhioRISE and for whom the treating providers indicate that PRTF service is necessary, the hospital will work with the OhioRISE care coordinator and/or Aetna's Transition of Care Coordinator to submit the PRTF Request Form and all relevant attachments to Aetna via the portal. If the youth has an inpatient hospitalization and the youth is already connected to OhioRISE, the hospital will reach out to Aetna's Transition of Care Coordinator for support connecting with the OhioRISE care coordinator making the PRTF referral, if needed.

After receiving a completed PRTF Request Form and supporting documentation, Aetna will review to ensure that the youth meets the clinical criteria for a PRTF intensity of service and provide a response to the care coordinator and the family/guardian/caregiver within three business days of receipt of a complete PRTF Request Form and required documentation. The PRTF Clinical Criteria can be found in [Appendix D](#).

Information Required at Time of PRTF Referral to Aetna

The OhioRISE care coordinator will provide information to Aetna using the PRTF Request Form. Information requested will include:

- Date of request
- Demographic information
- Current Diagnoses
- Reason for potential admission
- Documentation which psychiatrist (treating and/or CME's consulting) indicated PRTF intensity of service is appropriate for the youth
- Previous treatment information
- Information about current function
- Other Information and supporting documentation
- Aetna's PRTF Release of Information (ROI) so that submitted documentation can be shared with the PRTFs to whom the youth is referred

The PRTF Request Form can be found in [Appendix C](#) of this manual. If sufficient information is not received to determine if the youth meets PRTF medical necessity criteria, Aetna may reach out to the OhioRISE care coordinator to request additional information from providers to support the request for a PRTF admission.

Matching a Youth's Needs to an Available PRTF Provider

If Aetna determines the youth does not meet the clinical criteria for PRTF intensity of service, Aetna will notify the submitting OhioRISE care coordinator and the family/guardian/caregiver and include information about hearing rights. The decision will be available in the FamilyCare Central portal. The primary care coordination entity will convene the CFT to discuss alternative services and supports and to revise the CFCP to reflect updated plans to meet the youth's needs.

If Aetna has determined that the youth meets the clinical criteria for PRTF intensity of service Aetna will submit a referral to the PRTF that would best meet the youth's needs as close to the family/guardian/caregiver as possible. Identifying the most appropriate PRTF to meet the youth's needs may involve submission of additional documentation (e.g., recent treatment notes, IEPs) to Aetna.

Following the determination of medical need for PRTF services, Aetna will initiate referrals to a PRTF, matching a youth with a PRTF provider based on the youth's needs, the PRTF's admission criteria, and, whenever possible, proximity to the family/guardian/caregiver.

The OhioRISE care coordinator will be helpful to assist the PRTF in their efforts to provide information regarding the reason for referral, information from the most recent CANS, CFCP and other documents. CMEs may be helpful to work with the family/guardian/caregiver, youth and PRTF provider to develop proposed treatment goals (which are likely to be included in the CFCP) and assist in developing the tentative transition plan. As indicated in [Section 5](#), the PRTF provider will also be responsible for scheduling and coordinating meetings with the youth, family/guardian/caregiver, and OhioRISE care coordinator during the youth's tenure in the PRTF. PRTF providers will be expected to schedule the first meeting with the OhioRISE care coordinator at admission.

Upon or before admission, the PRTF provider will obtain the [Certification of Need](#), signed by a psychiatrist or another physician and a licensed mental health professional, that certifies:

- Ambulatory care resources available in the community do not meet the treatment needs of the youth;
- Proper treatment of the youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the youth's condition or prevent further regression so that the services will no longer be needed.

A CON template and further guidance can be found in [Appendix B](#).

Admission Criteria and Admissions

In a system wide effort to mutually achieve a no eject/reject system practice, the following strategies will be used:

1. PRTF providers will develop their own admission criteria, as approved by and in accordance with the contract with Aetna and assure that it has the staff and resources available to meet the needs of referred young persons who fit its admission criteria. Admission criteria will be provided to Aetna as part of the contracting process and revised annually. Admission criteria includes attention to age; gender; behaviors the PRTF will treat, which includes treating youth who display aggressive behaviors; exclusionary behaviors or diagnoses that the PRTF will not have the capacity to treat, if any, e.g., sexualized behaviors or eating disorders; and procedures to rapidly admit individuals referred by Aetna that meet the PRTF's admission criteria when the facility has an available bed. A young person who meets a PRTF's admission criteria must be found by Aetna to have documented needs that align with the medical necessity criteria in [Appendix D](#) for PRTF admission.
2. The PRTF provider will provide a daily bed census to facilitate appropriate referrals or divert referrals to other PRTF providers as needed. This information will be provided to the Aetna Residential Coordinator(s), whose responsibilities are to match young people approved for PRTF to the most appropriate treatment program. The PRTF programs will be responsible for keeping Aetna abreast of changes to their admission and exclusionary criteria, as well as whether environmental/milieu adjustments have taken place to meet the needs of youth currently being served there (e.g., if a youth in treatment has contacted a communicable condition and beds on the unit need to be closed for some time, if a unit/cottage is closed for repairs, staffing limitations, etc.) Aetna will work with the young person's CFT to ensure that the information being sent to potential PRTF programs is accurate and current. Aetna will help facilitate peer-to-peer discussions as needed between the young person's current treatment providers and potential PRTF to make sure any information gaps are closed.
3. Aetna will track and trend all decisions made by the PRTFs pertaining to member referrals. Should a PRTF decline a referral, they will need to provide a detailed reason explaining why, and this will be reviewed by Aetna's Medical Director. If the PRTF's response description is unsatisfactory, Aetna's Medical Director will have a conversation with the PRTF's clinical leadership to discuss the young person's case in detail. If a PRTF program declares a continued inability or resistance to treat a youth, the team may look for another match for therapeutic setting.

4. Careful controls and monitoring regarding the number and type of disputes will be maintained by Aetna and may result in regulatory action within the contract year. Any eject/reject activities will be addressed at the time of contract renewal.

Section 8: Pathway from PRTF

The PRTF will work with the youth's OhioRISE care coordinator and the CFT to support planning for transition immediately upon the youth's admission as reflected in the initial and each succeeding individual plan of care. Youth and family/guardian/caregiver voice are components of transition planning. Therefore, their input must be thoroughly considered and discussed throughout the transition planning process.

The PRTF Team will provide a transition action plan detailing week-to-week activities supporting a smooth and well-planned transition from PRTF. At a minimum, the transition action plan must include:

- Ongoing meetings with the youth and family/guardian/caregiver to discuss youth and family/guardian/caregiver strengths, continuing goals, successful strategies, and potential challenges.
- Plans for times during the transition phase when youth and/or family/guardian/caregiver may encounter difficulties that challenge transition. This plan will identify the critical staff necessary to re- focus, rally, and support the youth and family/guardian/caregiver through to transition.
- Action steps that youth and family/guardian/caregiver will take to build on successes and achievements that were accomplished during treatment.

In instances in which a youth may not already be engaged with an OhioRISE care coordinator at time of the PRTF admission, the PRTF Provider will work with Aetna to facilitate referral to a care coordinator and will work directly with the care coordinator and the CFT to support transition planning. The PRTF will not discharge a young person prior to completion of successful treatment, including if the young person temporarily leaves the PRTF for admission to a hospital for medical or psychiatric care, unless the youth is transferred to another PRTF provider whose admission criteria can better meet the youth's treatment needs. This does not permit a PRTF to refuse to discharge a young person when the legal custodian requests discharge. In some situations, it may be appropriate to transition a youth to a different provider or service, in these instances, written details will need to be submitted to Aetna for review and approval.

Transition/Return to the Community Plan

The goal of PRTF treatment is to prepare the child for the return to the community in the most family-centered or natural setting possible. It is critical that the process of transition planning

begin upon admission and continue throughout the entire course of treatment. The family is supported in being actively involved in the development of the plan for return to the community (or a transition plan for the child if placement/ permanency goals and/or court directives otherwise define transition goals). The Transition/Return to the Community Plan identifies the family's strengths, needs and cultural values previously identified in the individual plan of care, supports needed by the child and family after transition from the PRTF and living arrangements of the child after PRTF treatment is complete. In collaboration with the OhioRISE care coordinator, PRTF providers are expected to:

- Prioritize family/guardian/caregiver involvement in transition planning using a spectrum of practices including family therapy, parent skills training and family support groups. The family/guardian/caregiver is an equal and expert partner in the treatment and transition planning processes.
- Educate and communicate to families and other supports about the shared responsibilities involved in transition planning. Through the child's CFT, other involved supports, including child-serving systems are invited to remain actively involved with the child and family while receiving PRTF treatment.
- Identify and address barriers to transition at the onset of treatment.
- Develop realistic goals for completion prior to transition, in collaboration with the interagency team, and include the transition criteria on the individual plan of care. PRTF is an intervention intended to stabilize the youth and promote successful community reintegration.
- Define interventions that work for the youth and ensure that this information is integrated into the transition plan. Educate families/guardians/ caregivers about what interventions have proven to be most helpful to a youth.
- Ensure that therapeutic leaves/ home passes occur early in and throughout the treatment process. They are not to be approved or cancelled based upon behavior but viewed as opportunities to further treatment and transfer skills from the PRTF to the youth's home, school and or community.
- Help families/guardians/caregivers anticipate and respond to behaviors likely to occur during transitions (i.e., honeymooning, anxiety, ambivalence, limit testing).

Transition planning includes all of the following components:

- Transition planning meetings with the CFT at least monthly and more frequently when within 60 days of a planned transition date.
- Identification of triggers for relapse and a relapse prevention plan.
- Identification of family/guardian/caregiver supports.
- The PRTF, in coordination with the CFT, ensures that initial appointments for all follow-up services, including psychiatric medication management, are in place prior to

transition. The first therapy appointment is expected to be scheduled no more than seven days following the transition date.

- Arrangements for appropriate educational placement.

Follow-up Practices:

- Send written transition summaries to all involved systems within 7 days of transition.
- For at least six months post transition, PRTF providers will be available for consultation with the CFT team to share knowledge about interventions and practices that have been helpful to the child in the past and to assist the team in addressing any problems the youth may be experiencing post transition.
- PRTF providers will demonstrate they can work closely and collaboratively with a wider range of referring entities, including CMEs, around care coordination, transition support, planning and transition from PRTF.

Discharge Before Meeting Treatment Goals

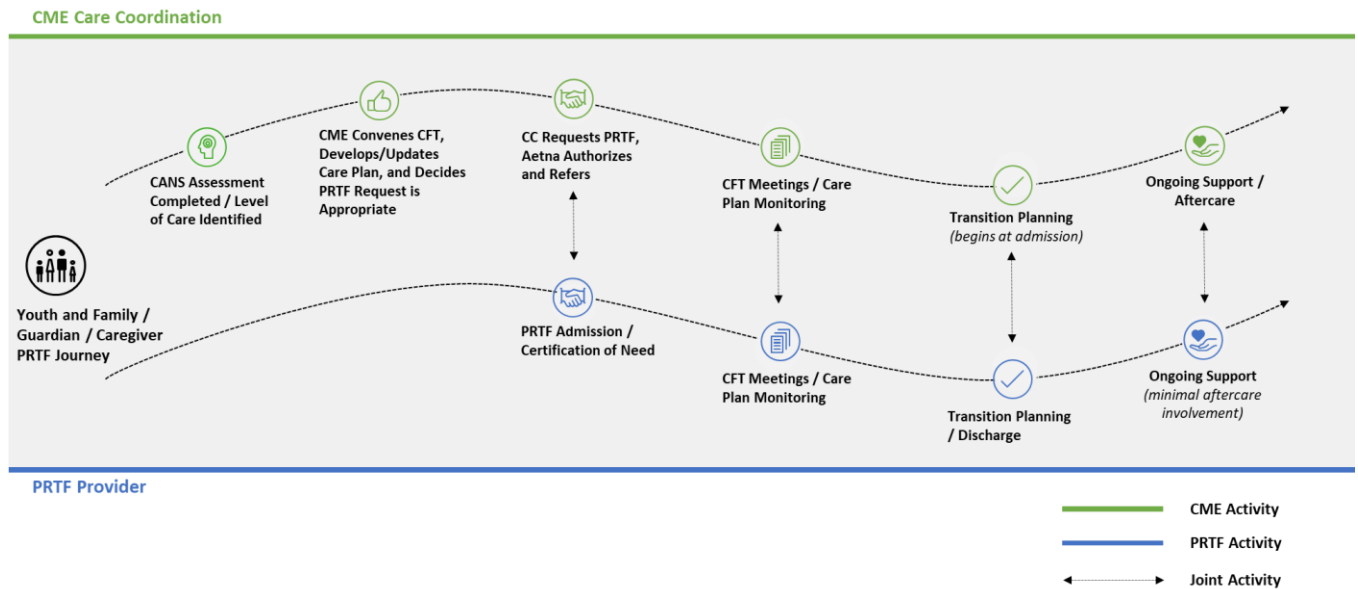
Under no circumstances may a provider discharge a youth without first contacting and receiving written approval from Aetna and the CFT. Once a PRTF has accepted a young person and during the course of treatment has determined that they can no longer adequately meet the needs of the young person, they must notify Aetna as soon as they make this determination, and work with Aetna and the CFT to transition the young person to a more appropriate treatment setting. They are expected to implement measures to help maintain the young person in the PRTF until a safe transition can be made. Issuing of 30-day discharge notices is not an option. The facility must submit this request in writing with supporting documentation. Aetna will make the final determination about disposition for the youth. Careful controls and monitoring regarding the number and type of disputes will be maintained by Aetna and may result in regulatory action within the contract year. Additionally, any eject/reject activities will be addressed at the time of contract renewal.

Section 9: Collaboration with Other System Partners

Collaboration with Aetna and CME Care Coordination

Most youth entering PRTF will already have an OhioRISE care coordinator engaged via a Care Management Entity, FCFC, or Aetna. These care coordinators will continue to provide care coordination, development of the Child and Family Centered Care Plan (CFCP), and ongoing convening of the Child and Family Team, in which the PRTF will participate.

Figure B: CME and PRTF Provider Collaboration on Admissions and Transitions



Collaboration with Children Services, Juvenile Justice, and Courts

PRTF is a medically necessary therapy service that is part of the home- and community-based continuum of services, and one component of a robust system of care.

While other types of residential services are licensed in Ohio and are paid for by sources other than Medicaid funding, PRTF is a Medicaid service that is distinct from other residential settings (e.g., QRTPs) designated for youth who are unable to remain in their own homes due to issues of abuse, neglect, and/or permanency that offer different levels of supervision and structure and focus on supporting youth in achieving permanency.

Some youth receiving PRTF services may be involved with Children’s Services, Juvenile Justice and/or courts. PRTFs must establish relationships with Title IV-E entities, PCSAs, courts and the department of youth services in their area to ensure both parties are informed of programming, services available and processes for admission. PRTF providers will work with and include these parties, as appropriate, in treatment planning, provision of medical care, and training opportunities.

Collaboration with County Boards of Developmental Disabilities

The PRTF shall contact the local county board prior to admission to describe the services offered, transition process and establish regular team meetings. The county board shall identify the SSA for the child as the main point of contact, the services offered by the county board, and the process for seeking enrollment on an HCBS waiver.

Section 10: Training

COE and the Innovations Institute Facilitated PRTF Learning Community

Each PRTF is required to participate in all Aetna-directed trainings, to include the COE-led Ohio PRTF Learning Community (LC), which is designed to provide participant with the tools necessary to meet the identified goals to support the delivery of PRTF services across the state of Ohio. The intended audience for this LC includes PRTF CEOs, clinical leaders and supervisors, and those in a PRTF oversight role. Each PRTF will identify an implementation team with a focus on community of practice to support the transfer of knowledge. These monthly LCs are designed to provide participants with the necessary tools and supports to share best practices with the intention that the tools are infused at all levels of the PRTF.

Expectations for Participants

It is anticipated that each PRTF organization will commit to support the transfer of knowledge through multiple mechanisms with the organization. Activities will include the identification of an implementation team in each PRTF with a focus of community of practice to support the transfer of knowledge. Implementation teams should include the PRTF Organizational Leadership and Clinical Leadership. To support the transfer of knowledge each session will be recorded and the materials and recording link will be provided.

Below is a schedule of topics to be covered by the LC across the next several months. The LC will tentatively meet on the 3rd Tuesday of every month from 2pm-3:30pm EST via Zoom. LC dates and times are subject to change.

LC Schedule	
Date/Time	Training Topics / Objectives
January 16, 2024 2pm-3:30pm EST	Introduction: PRTF within a System of Care: This session introduces the importance of a PRTF within Ohio’s children’s system of care. The focus is on shared vision, values, decision making and on cultural/linguistic competency and how the principles of a system of care support residential best practices. Focused discussion on the role of the PRTF provider, care coordination and the oversight organization.
February 20, 2024 2pm-3:30pm EST	Residential Best Practices: This session will focus on the general principles of residential best practices with a specific focus on PRTF within Ohio and how care coordination supports best practice care. Discussion of the role of leadership, youth, parent and caregivers and the community and shifting practice that supports non-coercive trauma informed care planning.
March 19, 2024 2pm-3:30pm EST	Trauma Informed Lens and Neurodevelopmental Approach: This session will focus on the steps necessary for organizations to shift to a trauma informed lens that recognizes neurodevelopmental approaches to care. Shifting practice from what is wrong with you to what happen to you with and supporting strategies to address elevated stress response systems. Trauma

	assessment, care planning and engagement strategies are essential components of organizational changes that recognize the needs of youth, families and the workforce.
April 16, 2024 2pm-3:30pm EST	Restraint/Seclusion and Coercion: This session will focus on the role of restraint, seclusion, and coercion within residential interventions. Focus on training, coaching, leadership, and the skills necessary to move to non-coercive care. Paul Rieger will share his experience in providing non-coercive care. Challenges and opportunities of residential best practices.
May 21, 2024 2pm-3:30pm EST	Psychotropic Medication: The session will focus on best practices in the use of psychotropic medication within a residential intervention. Discussion of strategies to minimize the use of medication to manage behavior. Discussion policy with a focus on best practice.
June 18, 2024 2pm-3:30pm EST	Addressing Special Populations: This session will focus on the needs of special populations inclusive of youth with substance use, intellectual/developmental disabilities challenges. Discussion on treatment interventions for youth who have demonstrated sexual inappropriate and aggressive behavior.
July 16, 2024 2pm-3:30pm EST	Advancing Equity, Diversity, and Inclusion: This session will focus on how cultural competency relates to equity, diversity, and inclusion. Discussion on the impact of structural racism on individuals served within residential interventions and the impact of the child servicing systems. Additionally, will focus attention on the role of historical trauma on youth, families, and the workforce within residential interventions.
August 20, 2024 2pm-3:30pm EST	Youth and Family Engagement: This session will focus on the importance of youth and family engagement within the treatment intervention and at the policy. Youth and peer support within the PRTF and care planning process and the elevation of youth and family voice in policy, practice and planning within each PRTF.
September 17, 2024 2pm-3:30pm EST	Workforce Development: Recruitment, Training, Coaching: This session will focus on developing a trauma informed workforce, inclusive of peer support, that can effectively and collaboratively engage children, youth, parents, and caregivers. A well-trained workforce can impact on both immediate and long-term outcomes for youth and families.
October 15, 2024 2pm-3:30pm EST	Individualized Care Planning: This session will focus on the connection of the PRTF treatment team and the care coordination entity, roles, and responsibilities. There will be discussion on the importance of an individualized care planning process with a focus on the youth and family goals, strategies for communication and transition. Discuss the importance of building an individualized team for each youth that includes formal and informal supports that focuses on treatment needs and developmental needs.
November 19, 2024 2pm-3:30pm EST	Measuring the Impact: This meeting explores the question of how we know how well we are doing. This meeting outlines the importance of data collection and analysis to assess performance and identify gaps in service. The success of PRTF in serving the youth and families is dependent on gathering the right data to understand how teams are delivering services, the short- and long-term outcomes of the children and families served, and for continuous quality improvement. The specifics of developing a quality improvement plan are discussed.

December 17, 2024 2pm-3:30pm EST	Residential Transformation: This session will focus on putting all the pieces together to tell the story of transformation within Ohio’s psychiatric residential treatment continuum.
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Staff Training

In addition to all Aetna-directed trainings, all PRTF staff are required to, at a minimum, complete the trainings in accordance with the following tables. As a best practice and in consideration of continuous quality improvement, PRTFs should consider additional trainings for staff to meet each facility’s goals.

Prior to working with youth in PRTF						
Training	Training Link (as applicable)	All Staff	Non-Clinical Staff	Supervisors	Clinical Staff	Volunteers
De-escalation strategies, which includes: <ul style="list-style-type: none"> • practicing techniques presented • crisis management • crisis prevention and intervention on the milieu • suicide prevention 	https://jfs.ohio.gov/child-and-adult-protection-foster-and-adoption/children-services-professionals/training/trauma-training-directory	X	X	X	X	X
PRTFs and Ohio's System of Care		X	X	X	X	X
Training and Demonstration of Competency in: Techniques to identify staff and individual behaviors, events, and environmental factors that may trigger seclusion or restraint.		X*	X*	X*	X*	
Training and Demonstration of Competency in: Use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, as alternatives to the use of seclusion and restraint.		X*	X*	X*	X*	

Training and Demonstration of Competency in: The safe use of restraint and seclusion		X*	X*	X*	X*	
Training and Demonstration of Competency in: The ability to recognize and respond to signs of physical distress in individuals who are restrained or in seclusion, including attention to vitals.		X*	X*	X*	X*	
Certification in cardiopulmonary resuscitation and first aid.		X*	X*	X*	X*	
Demonstrate competency in cardiopulmonary resuscitation and first aid.		X*	X*	X*	X*	
Training and Demonstration of Competency in: The ability to recognize signs of distress in youth to help reduce the use of seclusion and restraint through the use of trauma assessments, detection of early warning signs, and the development of calming/soothing plans and other strategies to help youth self-regulate.		X*	X*	X*	X*	
Did You Notice? Training for DSPs	https://dodd.ohio.gov/providers/DSP-Resources/Training/Training	X		X	X	
IDD for DSPs/TPWs and Care Coordinators	https://mylearning.dodd.ohio.gov/course/view.php?id=203	X		X	X	

Within 30 Days of Hire						
Training	Training Link (as applicable)	All Staff	Non-Clinical Staff	Supervisors	Clinical Staff	Volunteers
<p>Trauma-informed care training (must be one of the Trauma Training Models approved by OMHAS)</p> <p>Annual training should incorporate the following areas:</p> <ul style="list-style-type: none"> - Impact of trauma (brain, behaviors, relationships, learning, development) - Intergenerational trauma - Family engagement - Impact of trauma on attachment - Building resiliency - Experientially based regulation and co-regulation 	https://jfs.ohio.gov/child-and-adult-protection-foster-and-adoption/children-services-professionals/training/trauma-training-directory	X	X	X	X	X
<p>Evidence-based practices (EBPs) the PRTF is using from the chart below and how those EBPs are integrated into all of the levels of treatment within the organization:</p> <p>https://jfs.ohio.gov/static/ocf/FPSA-TraumaProgramIntervention.pdf</p>					X	
Cultural competence		X	X	X	X	X
Healthcare provider communications (specific to role that includes how to communicate with other providers)		X	X	X	X	X
Calming and coping strategies		X	X	X	X	X

Anti-bullying techniques		X	X	X	X	X
Emergency preparedness		X	X	X	X	X
Supporting Youth with Intensive and Complex Needs	https://dodd.ohio.gov/training/depart-ment-provided-training/supporting-youth	X	X	X	X	X

Within 90 Days of Hire					
Training	Training Link (as applicable)	All Staff and Volunteers	Non-Clinical Staff	Supervisors	Clinical Staff
Evidence-based practices (EBPs) the PRTF is using from the chart below and how those EBPs are integrated into all of the levels of treatment within the organization: https://jfs.ohio.gov/static/ocf/FFPSA-TraumaProgramIntervention.pdf			X	X	X
Mental Health First Aid for Youth			X		
Mental Health First Aid Intellectual Disability Guidelines			X		

Every 6 Months						
Training	Training Link (as applicable)	All Staff	Non-Clinical Staff	Supervisors	Clinical Staff	Volunteers

Training and Demonstration of Competency in: Techniques to identify staff and individual behaviors, events, and environmental factors that may trigger seclusion or restraint.		X	X	X	X	
Training and Demonstration of Competency in: Use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, as alternatives to the use of seclusion and restraint.		X	X	X	X	
Training and Demonstration of Competency in: The safe use of restraint and seclusion		X	X	X	X	
Training and Demonstration of Competency in: The ability to recognize and respond to signs of physical distress in individuals who are restrained or in seclusion, including attention to vitals.		X	X	X	X	
Demonstrate competency in cardiopulmonary resuscitation and first aid.		X	X	X	X	
Training and Demonstration of Competency in: The ability to recognize signs of distress in youth to help reduce the use of seclusion		X	X	X	X	

<p>and restraint through the use of trauma assessments, detection of early warning signs, and the development of calming/soothing plans and other strategies to help youth self-regulate.</p>						
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Annual						
Training	Training Link (as applicable)	All Staff	Non-Clinical Staff	Supervisors	Clinical Staff	Volunteers
<p>Trauma-informed care training (must be one of the Trauma Training Models approved by OMHAS) Annual training should incorporate the following areas:</p> <ul style="list-style-type: none"> - Impact of trauma (brain, behaviors, relationships, learning, development) - Intergenerational trauma - Family engagement - Impact of trauma on attachment - Building resiliency - Experientially based regulation and co-regulation 	<p>https://ifs.ohio.gov/child-and-adult-protection-foster-and-adoption/children-services-professionals/training/trauma-training-directory</p>	X	X	X	X	X
<p>Evidence-based practices (EBPs) the PRTF is using from the chart below and how those EBPs are integrated into all of the levels of treatment within the organization:</p>	-		X	X	X	

https://jfs.ohio.gov/static/ocf/FFPSA-TraumaProgramIntervention.pdf						
De-escalation strategies, which includes: - practicing techniques presented - crisis management - crisis prevention and intervention on the milieu - suicide prevention		X	X	X	X	X
Cultural competence		X	X	X	X	X
Emergency preparedness		X	X	X	X	X
Child and Youth Development (e.g., developmental stages and phases, milestones, brain development, etc.)		X	X	X	X	
Psychological Safety, Engagement and Collaborative Solutioning (e.g., MI/CPS, etc.)		X	X	X	X	
Behavioral Health and Psychiatric Disorders in Children and Youth, Diagnostics and Types of Treatment (including basics in psychopharmacology for caring professionals)		X	X	X	X	
System of Care Principles in Practice (youth/family engagement, voice/choice, individualization, accommodations, integrated care, etc.)		X	X	X	X	X
Other specialized training topics that are aligned with		X	X	X	X	X

the facility's target population and/or are identified as a need through the organization's continuous quality improvement processes, data trends, etc.						
Certification in cardiopulmonary resuscitation and first aid.		X	X	X	X	

Table Key	
	Specific to staff in PRTFs that include youth with intellectual/developmental disabilities in its admission criteria
	Counts toward annual 20 hours of Training required by OAC 5122-41-08(E)
	Specific to staff whose normal duties are to interact with the individuals served in the PRTF and any staff involved in the use of seclusion or restraint
	* Must be trained and demonstrate competency before participating in any restraint or seclusion intervention, in accordance with OAC 5122-26-16(F)

In addition to the training specified above, additional training requirements for providers and staff providing care for youth with MI/ID are outlined in [Appendix E](#).

Seclusion and Restraint Training

The provisions of this section are applicable to all direct care staff and any other staff involved in the use of seclusion and restraint. Staff will be trained and demonstrate competency before participating in any seclusion or restraint intervention.

The PRTF will mandate staff to have ongoing education and training. Staff training will include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency situations. As noted in the chart above, staff will have training in and demonstrate competency in the following at least once every six months:

- Techniques to identify staff and individual behaviors, events, and environmental factors that may trigger seclusion or restraint.
- The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, as alternatives to the use of seclusion and restraint.

- The safe use of restraint and seclusion, including the ability to recognize and respond to signs of physical distress in individuals who are restrained or in seclusion, including attention to vitals.
- Certification in cardiopulmonary resuscitation and first aid. After initial certification, staff shall be recertified either according to the time frame of a national first aid certifying body, e.g., the American red cross, or annually.

Individuals providing staff training will:

- Be qualified to do so by education, training, and experience.
- Document that staff received training and demonstrated competency. This will occur before staff participate in any seclusion or restraint intervention, and on an on-going basis:
 - Staff will be certified and recertified in cardiopulmonary resuscitation at least once every twelve months.
 - Staff will be certified and recertified in first aid. Staff certified by programs approved by the American Red Cross or the American Heart Association will be recertified in accordance with time frames established by these entities.
 - Staff certification under other first aid programs will be recertified at least once every twelve months unless a longer time frame is approved by the department.

The PRTF will document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation will include the date training was completed and the name of persons certifying the completion of training. All training programs and materials used by the PRTF will be available for review by Aetna, the Child and Adolescent Behavioral Health Center of Excellence (COE), ODM and CMS.

Section 11: Data and Quality

The PRTF collects and analyzes PRTF performance improvement and outcomes data to identify areas of focus and performance improvement in accordance with rules [5122-26-16](#), [5122-28-03](#) and [5122-28-04](#) of the OAC, including:

- Referral, e.g., response to referrals.
- Family/guardian/caregiver and young people engagement, e.g., participation in treatment team meetings.
- Transition, e.g., average length of stay, young persons transitioned to community setting.

The PRTF solicits and responds to any feedback from a young person or family/guardian/caregiver during the PRTF stay, and at transition.

Quality Improvement

Aetna is committed to continuous improvement and performance measurement as an important part of our partnership with PRTF providers. As part of that effort, Aetna seeks to actively and regularly collaborate with providers to improve program results. Aetna will include PRTF providers in the network who are focused on improving performance over time and expects all PRTF providers to engage and use data to monitor and understand performance, troubleshoot challenges, spread best practices, and adjust service delivery over time.

Expectations for this collaboration include, but are not limited to, attending bi-monthly provider meetings focused on performance. Aetna will conduct quality assurance reviews, site visits and review case files as needed to gain additional qualitative insight into treatment and program quality and compliance. PRTF providers will be expected to comply with any fidelity measures or processes required for any evidence-based practices or models they utilize.

Aetna anticipates focusing on a range of performance topics with selected providers including but not limited to:

- **Rapid acceptance of referrals and quick engagement with youth and their families:** This is critical to ensuring youth can be stabilized and begin to have their needs addressed as quickly as possible. The PRTF will collaborate with the OhioRISE care coordinator and the youth's child and family team before, during and for at least six months after PRTF treatment.
- **Provide a more home-like environment**
- **Reduced use of restraints/seclusion:** While necessary in rare cases, restraints and seclusion are harmful and used more often than desired today in our current residential system. We want to make progress toward our vision of eliminating this practice entirely.
- **Improving long-term program outcomes:** By regularly monitoring outcome goals like improving CANS scores (i.e., increase in strengths, decrease in needs) and successful transition (i.e., whether youth remains in a home-based setting after), Aetna and providers will be able to assess the success of residential programs, track the impact of actions taken to improve, and identify the need for broader programmatic changes.
- **Reducing lengths of stay:** We will monitor lengths of stay to ensure that treatment is being provided briefly, episodically, and appropriately at the level needed to achieve treatment goals so youth can quickly return to home-based settings.
- **Reducing staff turnover:** Retaining clinical staff (while creating space for internal advancement) is key to offering consistent, high-quality services. We anticipate monitoring turnover and sharing best practices across providers or exploring joint solutions to address capacity gaps.

- **PRTFs are expected to conduct and incorporate findings from satisfaction surveying** from youth, families/guardians/caregivers, and other providers on a regular basis.

COE and the Innovations Institute Facilitated PRTF Learning Community

Each PRTF is expected to participate in all Aetna-directed trainings, to include the COE-led Ohio PRTF Learning Community (LC), which is designed to provide participant with the tools necessary to meet the identified goals to support the delivery of PRTF services across the state of Ohio. The intended audience for this LC includes PRTF providers (CEOs, clinical leaders and supervisors) and those in a PRTF oversight role. Each PRTF will identify an implementation team with a focus on community of practice to support the transfer of knowledge. These monthly LCs are designed to provide participants with the necessary tools and supports to share best practices with the intention that the tools are infused at all levels of the PRTF.

Performance Metrics

To track progress in achieving programmatic goals, Aetna will monitor a set of performance indicators across all PRTF providers. These include outcome metrics that help assess overall programmatic success, as well as output and process data to help assess interim progress and manage service delivery.

Steady access to reliable and relevant data is critical to evaluate program results and performance, drive program improvements and policy decisions, inform budgeting, demonstrate savings to inform future investment in OhioRISE, and ensure compliance with the desired program model. As such, Aetna will request and collect other key data and metrics from PRTF providers including, but not limited to, client-level demographic, performance, and service utilization and delivery data. Aetna will provide the format and at a frequency for reporting. Aetna will work with PRTF agencies to help continue to build out the list of appropriate metrics over time.

Sample targets have been included for these metrics because Aetna will collaborate with providers to further develop this framework to ensure appropriate metrics are tracked for specific programs and sub- populations, and performance expectations. In addition, Aetna seeks to keep the focus on continuously improving performance on these metrics.

- In addition, Aetna will expect PRTF providers to collect and analyze facility specific PRTF performance improvement and outcomes data to identify areas of focus and performance improvement in accordance with rules [5122-26-16](#), [5122-28-03](#) and [5122-28-04](#) of the administrative code, including: Family/guardian/caregiver and young people engagement, e.g., participation in treatment team meetings.

- Transition, e.g., average length of stay, young persons transitioned to community setting.

PRTF providers will be expected to solicit and respond to feedback from a young person and/or family/guardian/caregiver during the PRTF stay and at transition.

Sample Operational Measures

Area	Item	Frequency
Census	# of occupied bed	Daily
	# of home visits	
	# available beds	
Admissions	Median time from referral to admission	Quarterly
Length of Stay	Individual length of stay per youth	Quarterly and annually
	Median length of stay	
	Days from admission to transition to less restrictive setting	
Staffing	Staff turnover by position (Specific Title) Staff Turnover by type (Direct Care vs. Clinical)	Monthly
	# of days the program does not meet contractually required staffing ratios	Daily and Quarterly
Restraint and Seclusion Reporting	# of restraint/seclusion incidents per youth Median # of restraints/seclusions overall % of restraint/seclusion incidents reported to all appropriate parties within the designated timeframe	Monthly
	% of youth with any restraint/seclusion during treatment stay	Quarterly
Family Contact and Child	# of contacts with families/guardians/caregivers per youth per month	Quarterly

and Family Team	% of treatment team meetings where family/guardian/caregiver participates per youth	Quarterly
	% of treatment team meetings where youth participates	Quarterly
	% of treatment team meetings where the OhioRISE care coordinator participates	Quarterly
	% of CFT meetings the PRTF did not attend	Quarterly

Sample PRTF Outcomes Measures

Measure	Frequency
% of youth transitioned to home-based or independent living setting who remain in that setting	30, 60-, 90-, 180- and 365-days post-transition
% of youth who remain post-transition in either a lower treatment setting OR home-based setting	30, 60-, 90-, 180-, and 365-days post-transition
% of youth discharged with unmet treatment plan goals	Quarterly
% of youth who have a follow-up appointment for post-transition services within 7 days of transition	Quarterly
Youth, family or other provider satisfaction surveys for 75% of all youth served at two points during the service period	Quarterly
80% of youth and families will demonstrate improved functioning (from time of intake to time of transition) as measured by independent, valid and reliable measures.	Annual

(Acceptable measures will be determined in collaboration with Aetna and the OhioRISE governing body)	
80% of all youth will be receiving the appropriate educational services 80% of the time while present at the PRTF program	Annual
75% of youth will transition from the PRTF to the community within six months of admission	Annual
% of all youth who do not incur new legal charges or violate existing charges while in treatment, 3, 6, 12 months after service	Annual
Number and percent of youth re-referred for PRTF or inpatient following transition from PRTF within 30, 60, 90, 180 and 365 days of transition	Annual
% of youth who had a home visit prior to transition back to the community	Quarterly

In addition, Aetna will collect and report to ODM the following youth-level data upon transition:

Measures	Frequency
Demographic information for each youth: <ul style="list-style-type: none"> • Age • Catchment Area • County • Referral reason • Reason for Transition 	Monthly, for youth who transition from the previous month
Key dates per youth: <ul style="list-style-type: none"> • Referral Date • Acceptance Date • Admission Date • Transition Date 	Monthly, for youth who transition from the previous month

<ul style="list-style-type: none"> Length of stay 	
CANS scores throughout PRTF treatment	Monthly, for youth who transition from the previous month
Number of Restraints/Seclusions	Monthly, for youth who transition from the previous month
Number of home visits while in treatment	Monthly, for youth who transition from the previous month
Transition information: <ul style="list-style-type: none"> Location Type of Location Referral linkage Type of services Date of first appointment Within 7 days (Y/N) 	Monthly, for youth who transition from the previous month

Reporting Data

Aetna is responsible for overseeing the initial and ongoing implementation of the OhioRISE Program. A major focus for these oversight efforts will be a review of PRTF services. Aetna, in partnership with the PRTFs, will collect and review important information to determine if the PRTF service is provided consistently with the vision and standards created by ODM and its state partners.

During the initial implementation of the PRTF services, PRTFs will be required to collect and report important information to Aetna. This information is intended to provide information regarding:

- Overall PRTF efforts
- Frequency and duration of PRTF service components
- Outcomes of youth who receive PRTF service

Critical Incidents

A PRTF must meet the incident reporting requirements of OAC rules [5122-30-16](#) and [5160-44-05](#). The state has an established system for reporting, reviewing, analyzing, and conducting remediation for all critical incidents. Most children and youth served by the OhioRISE Program are served not just by ODM. They receive and benefit from services provided by other state

agencies and local county partners. Ohio has robust reporting and investigation mechanisms for critical incidents, especially those concerning suspected child abuse and neglect, including those occurring in an out of home care setting requiring a report to the PCSA. The objective of reporting and managing critical incidents is to work in conjunction with various delivery systems to ensure the health and welfare of the youth. In addition, tracking critical incidents can:

- Support other investigative entities' open and ongoing critical incident cases.
- Ensure immediate health and welfare of the OhioRISE youth.
- Be used to analyze the root cause of a critical incident for each specific case for the purposes of informing preventative practices.
- Be used to track and trend patterns for the purposes of developing meaningful oversight and best practices for serving youth with multi-system needs.

ODM has defined critical incidents as follows:

Critical Incidents Definitions	
Incident	Definition
Abuse	The injury, confinement, control, intimidation, or punishment of an individual that has resulted in physical harm, pain, fear, or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal, or sexual abuse, or the use of restraint, seclusion or the use of restrictive intervention without authorization from the waiver case management agency, or the OhioRISE plan or its designee
Neglect	When there is a duty to do so, failing to provide an individual with any treatment, care, goods, or services necessary to maintain the health or welfare of the individual.
Exploitation	The unlawful or improper act of using an individual or an individual resources through the use of manipulation, intimidation, threats, deceptions, or coercion for monetary or personal benefit, profit, or gain
Misappropriation	The act of depriving, defrauding, or otherwise obtaining the money, real or personal property (including prescribed medication) of an individual by any means prohibited by law that could potentially impact the health and welfare of the individual.
Unnatural or Accidental Death	Death that could not have reasonably been expected, or the cause of death is not related to any known medical condition of the individual,

	including inadequate oversight of prescribed medication or misuse of prescribed medication.
Self-Harm or Suicide Attempt	Self-harm or suicide attempt that includes a physical attempt by an individual to harm themselves that results in emergency room treatment, in-patient observation, or hospital admission
Lost or Missing	The health and welfare of the individual is at risk due to the individual being lost or missing.

PRTFs must report incidents in accordance with rule [5160-44-05](#) of the OAC. While not specifically identified above, youth who leave a PRTF facility without permission is a critical quality issue that will be reported following the same timeframes and in the same manner as a Lost or Missing Critical Incident. The responsibilities of PRTF to report Critical Incidents are as follows:

Upon discovering an incident, the PRTF will assure the immediate health and safety of the youth and report the incident to the Aetna OhioRISE plan or its designee immediately upon discovery of the incident, but no later than twenty-four hours after discovering the incident, unless licensure or certification requirements require quicker reporting by sending an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com. For children and youth assigned to a CME Care Coordinator (or if there are questions regarding assignment) call 833-711-0773 (M-F 7am-8pm EST). The PRTF will also report the incident to Disability Rights Ohio (DRO) with Subject Line: 'Disability Rights Mental Health/PRTF Incident Report Submission; ATTN: Amy Price, Associate Advocacy Director' either via email to mhir@disabilityrightsohio.org or via fax to 614-644-1888. If the incident involved suspected child abuse or neglect, the PRTF will notify the PCSA, in accordance with ORC 2151.421. The PRTF will also post the attached DRO contact information sheet at the PRTF for easy children and youth access to contact information:



The report must include the name of the resident, a description of the occurrence, and the name, street address, and telephone number of the facility. In the case of a minor, the facility must notify the resident's parents, custodian, or legal guardian as soon as possible, and in no case later than twenty-four hours after the incident. Providers are also responsible for reporting Potential Quality of Care (PQoC) concerns to Aetna. Aetna Better Health's Quality Management department reviews the practitioner's/provider's report and follows up with the

practitioner/provider as necessary to confirm that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes.

If you believe an event may be a PQoC, email risepqoc@aetna.com within 2 business days to alert QM staff.

Serious Occurrence Reporting

A PRTF must also report serious occurrences in writing to Aetna, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Medicaid, and Disability Rights Ohio by the close of business the next business day following the incident. A serious occurrence is a child or youth death or suicide attempt and any serious injury that results in significant impairment of the physical condition of the child or youth, as determined by qualified medical personnel (includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else). Staff must document in the resident's record the date and time that the serious occurrence was reported, including the name of the person with the Ohio Department of Mental Health and Addiction Services, Ohio Department of Medicaid, and Disability Rights Ohio to whom the incident was reported, and the name of the parents, custodian, or legal guardian to whom the incident was reported. A copy of the report must be maintained in the youth's record and in the incident and accident report logs kept by the facility. In the instance of a youth's death while in the PRTF, the CMS Regional Office must also be notified.

Section 12: Claims Submission

Encounters, Claims, and Billing guidance can be found in [Appendix G](#) of this manual.

Section 13: Resources

Resource Title	Description
<u>Building Bridges Initiative (BBI)</u>	BBI is a national initiative working to identify and promote best practice and policy that will create strong and closely coordinated partnerships and collaborations between families/guardians/caregivers, youth, advocates, community and residential service providers, and oversight agencies.
<u>Wraparound Ohio</u>	Wraparound Ohio provides resources that range from research articles on systems of care to intervention and sustainability tools designed for youth, families/guardians/caregivers, their clinicians and

	communities, supervisors and system leaders, advocates and funders.
<u>The Child and Adolescent Needs and Strengths (CANS)</u>	The CANS is a multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of service.
<u>Ten Principles of the Wraparound Process</u>	The Wraparound theory assumes that, when wraparound is undertaken in accordance with the principles and the practice model specified by the NWI, the result is an effective team process that capitalizes on the expertise and commitment of all team members while also prioritizing the perspectives of the youth and family/guardian/caregiver.
<u>SAMHSA Tip 57: Trauma-Informed Care in Behavioral Health Settings</u>	Gathers experience and information for experts in behavioral health to highlight best practice guidelines to implementing a trauma-informed approach and services
<u>System of Care Definition and Philosophy</u>	A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.
<u>Systems of Care Principles</u>	Guiding principles that include interagency collaboration, individualized strengths-based care, cultural competence, family and youth involvement, community-based services, and accountability.

Section 14: Definitions

Term	Definition
Behavior Plan	A plan for goals that the treatment team and the youth work on to control the youth’s behavior.

Comfort Plan	An individualized plan that is established by the youth and staff that includes the youth’s personal triggers, warning signs and comfort measures that help the youth calm and self-soothe during periods of distress.
Family/Guardian/Caregiver	The individual/individuals identified in the permanency and concurrent plan that will ultimately support the timely and effective transition of the young person into the community.
Home-like Environment or Home-like	A living environment that provides for positive, nurturing interactions between caregivers and young people which may reduce the tensions of living in a group setting. Home-like environments provide softness and challenge, stability and flexibility, space for shared living and for private moments. Furnishings should be chosen for comfort as well as for durability. The home-like environment should include items such as artwork, artifacts, plants, pillows, and area rugs to add softness. The selection of wall colors, lighting fixtures, furniture, window treatments, floor coverings, and decorative accessories should also enhance the home-like environment. The home-like environment should not compromise the health and safety considerations of the young people residing in the PRTF.
Individual Plan of Care	A plan developed with the family/guardian/caregiver and youth, describing measurable goals that the youth and family/guardian/caregiver want to attain, the interventions, and how progress towards the goals will be monitored with a focus on addressing the issues that are leading to the need for behavioral health services within a PRTF setting.
Psychiatric Residential Treatment Facility (PRTF)	A trauma-informed, inpatient level, intensive multi-disciplinary residential treatment provided in a non-acute setting for young people with complex needs, as defined in Chapters 5122-41 and 5160-59 of the OAC. A PRTF delivers trauma-informed, evidence-based individualized services to young people in order to stabilize behaviors in as short as possible time frame, help young people and their family/guardian/caregiver to develop the knowledge and skills needed to safely manage their needs in the community, so that the young person can succeed in all aspects of community living, e.g., home and family, school, employment, etc.

Safety Plan	A plan developed for staff on how to positively approach a youth when a specific behavior begins to escalate. The safety plan may be implemented in an immediate and expedient manner to manage imminent safety issues by a unit staff member, treatment team member or clinical leadership when a youth's risk behaviors disrupt the milieu.
Serious Injury	Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.
Services Plan	A written statement that describes the special education and related services the school district will provide to a parentally placed child with a disability enrolled in a nonpublic school who has been designated to receive services, including the location of the services and any transportation necessary, consistent with rule 3301-51-08 of the Administrative Code, and is developed and implemented in accordance with rule 3301-51-08 of the Administrative Code.
Transition	A young person has met their treatment goals and is transitioning to a community setting or a lower level of residential care including a group home.
Youth	A child, youth, or young adult under the age of twenty-one.

Definitions Related to Restraint and Seclusion

The following definitions shall apply to rules [5122-26-16](#) to [5122-26-16.1](#) of the Administrative Code and are in addition to those contained in rule [5122-24-01](#) of the Administrative Code:

Term	Definition
Advance directives	A legal document used by an adult to direct in advance the mental or physical health treatment in the event the adult lacks the capacity to make such decisions. Two types of advance directives related to mental health treatment are a "Declaration for Mental Health Treatment" subject to the requirements of Chapter 2135 of the Revised Code, and a "Durable Power of

	Attorney for Health Care” subject to the requirements of sections 1337.11 to 1337.17 of the Revised Code.
Behavior management	<p>The utilization of interventions applied in a systematic and contingent manner in the context of individual or group programs to change or manage behavior or facilitate improved self-control.</p> <p>The goal of behavior management is not to curtail or circumvent an individual’s rights or human dignity, but rather to support the individual’s recovery and increase the individual’s ability to exercise those rights.</p>
Comfort rooms	Adapted sensory rooms that provide sanctuary from stress or can be places for persons to experience feelings within acceptable boundaries. Formerly known as “quiet” or “time-out” rooms.
Emergency safety intervention	The use of restraint or seclusion as an immediate response to an emergency safety situation.
Emergency safety situation	Unanticipated youth behavior that places the youth or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.
Individual crisis plan	A written plan that allows the person to identify coping techniques and share with staff what is helpful in assisting to regain control of the person’s behavior in the early stages of a crisis. It may also be referred to as a “behavior support plan.”
Licensed independent practitioner	An individual authorized by the provider to order seclusion and restraint. A licensed independent practitioner includes a “medical practitioner authorized to order seclusion and restraint,” as well as any other practitioner that has ordering seclusion and restraint in their scope of practice.
Mechanical restraint	Any method of restricting a person’s freedom of movement, physical activity, or normal use of their body, using an appliance or device manufactured for this purpose.

Medical practitioner authorized to order seclusion and restraint	An individual who is authorized by the provider to order seclusion and restraint and who is a psychiatrist or other physician, or a physician's assistant, certified nurse practitioner or clinical nurse specialist authorized to order restraint or seclusion in accordance with his or her scope of practice and as permitted by applicable law or regulation.
Order	Written or verbal authorization to implement seclusion or restraint
Physical restraint	Also known as "manual restraint", means any method of physically restricting a person's freedom of movement, physical activity, or normal use of the person's body without the use of mechanical restraint devices. Transitional holds are not physical restraint.
PRN (pro re nata)	As the situation demands. Orders for seclusion or restraint may not be on a standing or PRN basis.
Prone Restraint	All items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a facedown position. Prone restraint may include either physical (also known as manual) or mechanical restraint.
Qualified person	An employee or volunteer who carries out the agency's tasks under the agency's administration and/or supervision, and who is qualified to utilize or participate in the utilization of seclusion or restraint by virtue of the following: education, training, experience, competence, registration, certification, or applicable licensure, law, or regulation.
Seclusion	The involuntary confinement of a person alone in a room where the person is physically prevented from leaving.
Sensory rooms	Appealing physical spaces painted with soft colors with the availability of furnishings and objects that promote relaxation and/or stimulation.

Time-out	An intervention in which a person is required to remove them self from positive reinforcement to a specified place for a specified period, for the purpose of providing the individual an opportunity to regain self-control. Time-out is not seclusion or restraint, including it does not include physically preventing an individual from leaving a room.
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Section 15: Acronyms

Acronym	Definition
ACE	Adverse Childhood Event
ASAM	American Society of Addiction Medicine
BCBA	Board Certified Behavior Analyst
BH	Behavioral Health
CANS	Child and Adolescent Needs and Strengths
CC	Care Coordinator
CFCP	Child and Family-Centered Care Plan
CFR	Code of Federal Regulations
CFT	Child and Family Team
CME	Care Management Entity
CMS	Centers for Medicare and Medicaid Services
CON	Certification of Need
DODD	Ohio Department of Developmental Disabilities
DYS	Ohio Department of Youth Services
EMIS	Education Management Information System

ESC	Educational Services Center
FCFC	Ohio Family and Children First Council
IEP	Individualized Education Program
MCO	Managed Care Organization
MH	Mental Health
MI/ID	Mental Illness and Intellectual or Developmental Disability
MOU	Memorandum of Understanding
OAC	Ohio Administrative Code
OCALI	Ohio Center for Autism and Low Incidence
ODE	Ohio Department of Education
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODM	Ohio Department of Medicaid
OhioMHAS	Ohio Department of Mental Health and Addiction Services
OT	Occupational Therapy
PCSA	Public Children Services Agency
PRTF	Psychiatric Residential Treatment Facility as defined by 42 C.F.R. 483.354 , as authorized under section 1905 (a)(16) and (h) of the Social Security Act and described in Chapters 5122-41 and 5160-59 of the Ohio Administrative Code.
PT	Physical Therapy
QRTP	Qualified Residential Treatment Program
SA	Survey Agency

SAMHSA	Substance Abuse and Mental Health Services Administration
SOC	Systems of Care
TTG	Targeted Treatment Goal

Appendix A: PRTF Provider CMS Attestation Form

Per CMS requirements, the facility's executive director, chief executive officer, president, or similar position must provide an attestation certifying it is compliant with CMS standards governing the use of restraint and seclusion. A copy of this attestation must be provided to ODM within seven calendar days of enrolling as a PRTF provider, by July 21 each year, and at any time the individual with the legal authority to obligate the facility is no longer in such position.



Ohio PRTF
Attestation Form.pdf

Appendix B: Certification of Need

[42 C.F.R. 441.152](#) requires Certification of Need for Psychiatric Residential Treatment Facility (PRTF) services to be documented in the youth's PRTF record. The below has been created as a template for Ohio's PRTFs to meet this requirement.

The CON should be completed, signed by the appropriate PRTF interdisciplinary treatment team members as noted below, and stored in the youth's record within 14 days of admission.

Upon or before admission, the PRTF provider will obtain the Certification of Need, signed by a psychiatrist or another physician and a licensed mental health professional, that certifies:

- Ambulatory care resources available in the community do not meet the treatment needs of the youth;
- Proper treatment of the youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the youth's condition or prevent further regression so that the services will no longer be needed.



PRTF CON

Appendix C: PRTF Request Form

Hard copies of this form will not be accepted. This form is here for reference and is the basis for the PRTF Request Form portal in Aetna’s FamilyCare Central portal, which will be entered by the OhioRISE care coordinator.

Youth Name:	First and Last
Medicaid ID:	
Date of Birth	
Custodian/Guardian	
Reason for Referral:	
Request Date:	
Primary Referral Behavior (within the past three months):	
Person Completing Request form:	Name, Phone, Email

Previous Treatment Information: include Primary, Residential, Psychiatric Hospitalizations and other Behavioral Health Services: (What services have already been utilized?)

For OhioRISE members: this information may be pulled from an existing record

For those not already in OhioRISE – this information will need to be added directly to the form

Month/Year Start	Month/Year End	Type of Tx Service	Name of Tx/ Service	Effectiveness (Family view)	Is current? (Y/N)	Reason for Treatment?

Prior to submitting the PRTF Request, the OhioRISE care coordinator shall complete the following checklist and obtain the documentation identified below, so that that all necessary information is available for review at the time of submission of the request. A PRTF request should be submitted when all required documentation and all supplemental documentation relevant to the youth has been gathered for review.

Minimal Documentation Requirements:

PRTF Request Form completed by the youth’s OhioRISE care coordinator in consultation with the Child and Family Team, treating Psychiatrist or CME Psychiatrist _____ (MD name and Facility) and all are in support of this referral.

Diagnostic Evaluation (completed by Psychiatrist or Psychologist within the last (6) six months)

At least one of the following must be included (if not already available to Aetna):

- Child and Family Centered Care Plan (CFCP) indicating PRTF recommendation
- Hospital Discharge Plan w/ PRTF Recommendation
- Inpatient Evaluation
- FCFC Service Plan
- Most recent CANS Assessment indicating PRTF need

If checking CFCP or CANS Assessment, this should be pulled by Aetna team since they have access to this document.

Hospital Transition Plan if this is youth’s entry into OhioRISE and this in the only documentation to support PRTF

Other Required Documents (see italicized information for required criteria):	
<input type="checkbox"/> Psychiatric Evaluation/Progress Note (within last 3 months*):	
➤ IS REQUIRED if youth is prescribed <i>psychotropic medication</i>	
➤ IS REQUIRED if youth had a <i>psychiatric hospitalization within the last six months</i>	
➤ IS REQUIRED if youth is <i>actively seeing a psychiatrist</i>	
*If the evaluation is more than three months old, CC must provide the evaluation along with an accompanying updated report from the treating psychiatrist. If youth is prescribed psychotropic medication, the report should specify current diagnosis, current medication name/dosage, and noted response to medication.	
<input type="checkbox"/> Specialty Evaluations (within the last six months):	<input type="checkbox"/> Not Applicable
If any of the below behaviors have been present in the last 6 months, please provide documented details related to the behaviors and include any relevant specialty evaluations associated with the behavior.	
<input type="checkbox"/> Fire Setting Behaviors	Level of Intensity/Focus of Current Treatment)
<input type="checkbox"/> Problem Sexual Behavior	Level of Intensity/Focus of Current Treatment)
<input type="checkbox"/> Eating Disorder	Level of Intensity/Focus of Current Treatment)
<input type="checkbox"/> History of severe aggression	Level of Intensity/Focus of Current Treatment)
<input type="checkbox"/> Other	Level of Intensity/Focus of Current Treatment)
Substance Use (SU) Assessment (within last 30 days) for youth for whom consent has been obtained DO NOT UPLOAD SU ASSESSMENTS without consent!	
<input type="checkbox"/> Substance Use Consent Form	
<input type="checkbox"/> Other Assessments or Clinical Information from additional providers (not required)	
<input type="checkbox"/> Psychological Evaluation	
<input type="checkbox"/> Treatment/Clinical Summary	
IDD Specific Evaluations/Reports <input type="checkbox"/> Not Applicable	
<i>IS REQUIRED if youth is deemed DODD Eligible and/or has a MI/ID</i>	
Report(s) that capture the youth's level of functioning and special needs within the domains of the following area must be included:	
<input type="checkbox"/> Communication	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Mobility	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Life skills	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Cognition	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Sensory	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Special equipment	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Adaptive Functional Skills (MI/ID)	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Cognitive Capabilities (MI/ID)	<i>Report or evaluation providing this information (drop down)</i>
<input type="checkbox"/> Community Functioning (MI/ID)	<i>Report or evaluation providing this information (drop down)</i>
Please indicate where the above information is included in already required documentation or list any DD specific evaluations or reports that include the information	

Other Reports/Evaluations (as applicable):		<input type="checkbox"/> Not Applicable
<input type="checkbox"/> IEP, if available but not required (Can also be acquired once PRTF linkage has been made)		
<input type="checkbox"/> Medical reports (required if the youth has any of the following medical conditions):		
<input type="checkbox"/> Pregnancy	<u>Special Needs/Accommodations:</u>	
<input type="checkbox"/> Diabetes	<u>Special Needs/Accommodations:</u>	
<input type="checkbox"/> Allergies	<u>Special Needs/Accommodations:</u>	
<input type="checkbox"/> Seizures	<u>Special Needs/Accommodations:</u>	
<input type="checkbox"/> Medications	<u>Special Needs/Accommodations:</u>	
<input type="checkbox"/> Medical Equipment	<u>Special Needs/Accommodations:</u>	
<input type="checkbox"/> Other	<u>Special Needs/Accommodations:</u>	
<input type="checkbox"/> Inpatient Hospital Intake Assessment and/or transition summary		
IF THE YOUTH IS INVOLVED WITH COURT		<input type="checkbox"/> Not Applicable
Date of Next court hearing:	Date	
Legal Charges:	List	
Probation Status:	List	
Probation Officer Name and Contact information	Name, phone, email	

Appendix D: PRTF Clinical Criteria

Service/Admission Guidelines	
Psychiatric Residential Treatment Facility (PRTF)	
<i>PRTF Service Description</i>	
<p>A highly structured inpatient intensity of service setting that brings comprehensive and specialized diagnostic and treatment services to youth and their families. The youth entering these programs require intensive treatment services on a 24/7 basis in a safe environment with a high level of supervision, medication monitoring and management, and a concentrated individualized treatment protocol. PRTF is a specialized treatment service that supports youth with chronic behavioral health needs that would not be addressed in an acute psychiatric hospital stay meant to stabilize a mental health crisis.</p> <p>Youth entering the PRTF program may be referred by a youth's CFT via the youth's OhioRISE CME or Aetna Better Health of Ohio as a result of a youth's inability to be maintained in a lower-intensity community program or lower-level residential program with a reasonable degree of safety. In situations where a behavioral health, psychiatric admission results in connection to the OhioRISE plan, a hospital may make a referral through the Aetna Transition of Care Coordinator.</p>	
<i>Clinical Criteria</i>	
Admission Criteria	<p>At the time of admission, youth meets all criteria: A through I</p> <ul style="list-style-type: none"> A. The youth meets the age range for the specific PRTF program. B. The youth has a primary mental health DSM 5 diagnosis, OR a primary mental health DSM 5 diagnosis and a co-occurring substance use disorder. C. The youth is involved in multiple child-serving systems in order to address their complex needs, or the involvement in one system is so intense that symptoms require assistance or intervention by police, courts, educational system, mental health system, social service, human services and/or children services. D. Severe or marked emotional or behavioral impairment in most areas of social functioning, as evidenced by at least <u>one of the following</u>:

	<ol style="list-style-type: none"> 1. Inability or unwillingness to cooperate or participate in daily self-care activities due to symptoms of the diagnosis or due to severe anxieties, severe withdrawal, isolation, severe mood fluctuations, psychosis, and/or severe depressed mood. 2. Suicidal preoccupation or rumination with or without lethal intent or is a potential danger to self due to significant self-injurious behaviors or chronic suicidal ideation, without a specific plan or intent. 3. Inability or unwillingness to attend school due to symptoms of the diagnosis or due to severe anxieties, severe withdrawal, isolation, severe mood fluctuations, psychosis, and/or severe depressed mood. 4. Obsessive rituals, frequent anxiety attacks or major conversion symptoms that impact daily life. 5. Frequent episodes of aggressive behavior that compromise the safety of others in their proximity. 6. Impairment so severe as to preclude observation of social functioning or assessment of symptoms related to anxiety (i.e., depression or psychosis so severe, assessment or observation of social functioning is not possible at this time). <p>E. Impairment that seriously disrupts family and/or interpersonal relationships, as evidenced by at least <u>one of the following</u>:</p> <ol style="list-style-type: none"> 1. Symptoms of the diagnosis prevent participation in age-appropriate activities. 2. Symptoms have led to documented impairment in the community (home, school or peers). 3. Behavior is life-threatening (suicidal, homicidal), or otherwise potentially able to cause serious injury to self or others. <p>F. Evidence that an item in D or E has not responded to alternative treatment, has been intractable or, despite treatment, continues to persist or worsen.</p> <p>G. The youth's current emotional and behavioral presentation is not stable enough to be treated outside of a highly structured therapeutic environment, which offers 24-hour clinical monitoring and supervision.</p> <p>H. The youth's current emotional or behavioral impairment identified in D or E impairs the youth's functioning in more than one life domain.</p> <p>I. The Ohio Children's Initiatives CANS Assessment indicates that the youth's presenting treatment needs are consistent with PRTF intensity of service, or in the absence of a completed</p>
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	CANS, or a CANS recommendation that does not result in a PRTF recommendation, other relevant clinical information that justifies the need for the PRTF intensity of service.
Exclusion Criteria	<p>Any of the following is sufficient for exclusion from the PRTF intensity of service:</p> <ul style="list-style-type: none"> A. The youth is at imminent risk of causing serious harm to self or others. B. The youth (18 or older) and/or the family/guardian/ caregiver does not voluntarily consent to treatment C. The youth has primary treatment needs consistent with a Substance Use Disorder and requires immediate medical treatment or intervention, such as withdrawal management or detoxification services. D. The youth presents with symptoms and behaviors consistent with a sole diagnosis of a Substance Use Disorder E. The Ohio Children’s Initiatives CANS Assessment and/or other relevant clinical information indicate that the youth needs a higher intensity treatment program or a lower intensity treatment program.
Continued Stay Criteria (Youth Specific)	<p>All of the following criteria are necessary for continuing treatment at the PRTF intensity of service:</p> <ul style="list-style-type: none"> A. There is evidence that the youth continues to demonstrate severe emotional or behavioral symptoms that continue to impact/impair functioning, and continue to require the PRTF intensity of service. B. The Ohio Children’s Initiatives CANS Assessment and/or other relevant information indicate the youth continues to need the PRTF Intensity of Service. C. The youth’s treatment does not require a higher Intensity of Service treatment program or a lower Intensity of Service treatment program. D. Services at this Intensity of Service continue to be required to support reintegration of the youth into a less restrictive environment. E. The youth and the parent/guardian/caregiver or other individuals identified by the youth are actively participating in treatment, to the fullest extent possible. F. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved and adjustments in the individual plan of care include strategies for achieving these unmet goals for those instances where, during a continued stay review, a youth does not appear to be

	<p>progressing, the team has developed an alternative approach to treatments and supports to be trialed over the next stay review period, with clearly identified milestones and timelines to monitor progress.</p> <p>G. There is documented evidence of active, individualized transition planning.</p>
<p>Continued Stay Criteria (PRTF Responsibility)</p>	<p>A. The individual plan of care is appropriate to the youth's presenting treatment needs, with realistic and specific goals and objectives that include target dates for accomplishment.</p> <p>B. Individualized services and treatments are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.</p> <p>C. When clinically necessary, appropriate psychopharmacological evaluation has been completed and ongoing treatment is initiated and monitored.</p>
<p>Transition Criteria</p>	<p>Please indicate which of the following criteria are met for transition: <i>*Required for all transitions; others as they apply to individual youth/family/caregivers:</i></p> <p>A. *The youth's documented treatment plan goals and objectives for this intensity of service, as reported in the youth's individual plan of care, have been met or have documented progress and barriers toward meeting goals.</p> <p>B. *There is documented justification that youth meets the criteria for a higher intensity of service treatment program or a lower intensity of service treatment program.</p> <p>C. *The youth and the youth's family/guardian/caregiver have been connected to OhioRISE Care Coordination.</p> <p>D. The youth and/or the parent/guardian/ caregiver are competent but non-participatory in treatment or non-adherent with the treatment program's rules and regulations. The nonadherence is significant enough to negatively impact the overall treatment course and compromises the youth's ability to have a successful, positive response to treatment. Attempts at ongoing engagement to increase participation and adherence should be documented in the youth's treatment plan over time before the consideration of a placement/treatment transition.</p> <p>E. There has been limited progress toward treatment goals with no reasonable expectation of progress at this intensity of service, despite attempts to modify and revise the individual plan of care for the benefit of the youth.</p> <p>F. The Ohio Children's Initiatives CANS Assessment and/or other relevant information indicate that the youth needs a higher</p>

	<p>intensity treatment program or a lower intensity treatment program.</p> <p>G. Consent for treatment is withdrawn by the family/guardian/caregiver and/or the youth.</p> <p>H. Young person transitioning from PRTF to independent living, or adulthood, ensure that support systems and specific therapeutic services to maintain stability in a lower level of care have been identified and set up prior to transition.</p> <p>I. A youth's support systems and specific therapeutic services (which allow the youth to be maintained in a lower Intensity of Service treatment program) have been identified, documented and set up prior to the transition of the youth. Ideally, the youth and community-based treatment provider have had at least one, if not more, transition sessions prior to the transition occurring.</p> <p>J. *A comprehensive transition plan has been developed with family/guardian/caregiver along with the child and family team to include contingency planning to address any significant changes for the youth after transition and includes local community supports and services, which includes a follow-up appointment within seven calendar days of transition.</p>
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Appendix E: Criteria for PRTFs Serving Youth with MI/ID

The PRTF for individuals with co-occurring behavioral health needs and intellectual and developmental disabilities (MI/ID) will be staffed with direct care staff trained to provide care for persons with MI/ID; the staff will be provided MI/ID specific training by DODD and OhioMHAS. Staffing ratios will be individual-specific and circumstance-based. PRTFs for youth with MI/ID will address communication challenges with adapted communication and interviewing techniques as well as adapted crisis management and de-escalation techniques. All comments regarding MI/ID also apply to youth with traumatic brain injuries, neurocognitive disorders, and other cognitive deficits regardless of their etiology.

Admissions Components

1. A physical health examination by a physician or advanced practice registered nurse is required for all youth not later than twenty-four hours after admission, to include an expanded laboratory (bloodwork) panel and other diagnostics.
 - a. At times, youth with MI/ID will present with decreased self-report and low threshold for other objective data to rule out undiagnosed medical conditions. Personal Protective Equipment will be carefully considered as persons with MI/ID are at increased risk of COVID-19 and other infectious diseases due to potential decreased self-report of symptoms (resulting in delayed diagnosis), as well as vulnerability to pulmonary and central nervous system conditions.
2. Psychiatric assessment and consultation (including input into the clinical component of an individualized treatment plan).
 - For youth with intellectual disability, psychiatric consultation will be available by psychiatrists with training or expertise in MI/ID. The consultation may involve a collateral data source for those youth with limited expressive language skills. DODD can facilitate linkage with resources if needed.
3. Strengths based bio-psychosocial assessment. For youth with MI/ID, the developmental stage of the youth (mild, moderate, or severe ID) will also be considered and integrated into a bio-psycho-social-developmental assessment and plan.
4. Access and connection to other services such as:
 - Psychological testing
 - Vocational counseling
 - Medical services, to include vision and dental screening, as needed
 - Individualized therapeutic ancillary support materials and/or therapeutic support devices
 - Sensory informed OT evaluation and communication evaluation for youth with MI/ID
 - Ancillary services:

- Youth with MI/ID will receive educational services according to their individualized educational plan.
- Organized recreational activities to support normative developmental experiences, i.e., outdoor play, relaxation, interests. Youth with MI/ID will be offered recreational services that accommodate their individual medical, neurological and physical needs and capabilities.

Criteria for PRTF Providers Contracted to Serve Youth with MI/ID

If necessary, youth with intellectual disability may be evaluated using telemedicine (or a psychiatrist with expertise in MI/ID may provide consultation to the treating physician upon request of PRTF medical staff). Referral to the DODD cross-system behavioral health and support team should be made to determine the appropriateness of a referral to the Multi-Disciplinary Comprehensive Assessment Team and Regional Family Coach. Consultation with OCALI for an environmental review should be completed. DODD can arrange linkage to these resources.

Consultation with the psychiatrist should allow for more frequent and longer appointments to accommodate communication challenges, including limitations in expressive language skills.

- Individual counseling sessions using adapted techniques for MI/ID for at least 90 minutes weekly; persons with MI/ID may require shorter length and more frequent sessions due to memory and attention span difficulties
- Group therapy adapted for youth with MI/ID
- Medication administration (including de-prescribing as indicated), substance use treatment and family/guardian/caregiver therapy will be adapted for MI/ID
- Sensory evaluation, Sensory OT, PT, BCBA, and Behavior Support Specialist will have knowledge of MI/ID. The treatment plan will include a Behavior Support Specialists, as well as alternative treatments such as music, art, and recreation
- In general, the length of stay for treatment effectiveness in both inpatient and outpatient settings for persons with MI/ID is longer due to time to acclimate and time to understand/retain new principles and new coping skills
- Individualized service plans for MI/ID should consider the use of technology to increase independence, autonomy, and quality of life for youth with ID; they should also combine the philosophy of MH (recovery) with the philosophy of ID (self-determination)
- Environmental modifications such as paint color, lighting, auditory adaptations, and furniture to address the needs for youth with MI/ID will be available. There will be separate wings/units/cottages based on gender

- As with all PRTFs in Ohio, there will be a no eject/reject policy for youth with MI/ID that includes a comprehensive team evaluation of the youth including a bio-psycho-social-developmental formulation to inform clinical decision-making

Education Services

Education services that meet the minimum standards prescribed by the state board of education, whether through a public school, community school, or chartered nonpublic (private) school operated by or at the PRTF. The PRTF must coordinate education services with the young person's school district when applicable. All youth, including those with MI/ID will receive educational services according to their individualized educational plan. For youth with intellectual disability, the PRTF will request consultation with OCALI as needed. Educational liaison between the onsite educational programming and the LEA/Local Team/Family will occur.

Seclusion and Restraint

In addition to the training listed in [Section 10](#), care providers for youth with MI/ID must receive specialized training in the area of Seclusion and Restraints due to the multiple neurological, cardiac, and pulmonary needs of the MI/ID patient population to address the increased safety risks and potential limited verbal capabilities/self-report of the youth.

PRTF Building and Living Requirements

For youth with intellectual disabilities, building and living arrangements will abide by the requirements set forth by the Americans with Disabilities Act, which includes environmental modifications for paint color, lighting, auditory adaptations, and furniture.

Staffing

Psychiatrists providing treatment for youth with MI/ID should have training or experience with MI/ID patient population. Individuals providing direct care for youth with MI/ID will have received additional training for meeting the needs of individuals with developmental disabilities.

Clinical Criteria for the PRTF-MI/ID

Service/Admission Guidelines
Psychiatric Residential Treatment Facility – (PRTF-MI/ID)
<p><i>Service Description</i></p> <p>A highly structured inpatient intensity of service setting that brings comprehensive and specialized diagnostic and treatment services to youth and who present severe and</p>

persistent challenges in social, emotional, behavioral, and/or psychiatric functioning with a co-occurring MI/ID. The youth entering these programs require intensive treatment services on a 24/7 basis in a safe environment with a high level of supervision, medication monitoring and management, and a concentrated individualized treatment protocol. The agency/program provides rehabilitative services including, but not limited to, social, psychosocial, clinical, medical, and educational services, which are integrated with coordinated supports, and training that may include behavioral supports, adaptive skill training, prompts for activities of daily living and community integration as is deemed appropriate in the Care Plan. PRTF is a specialized treatment service that supports youth with chronic behavioral health needs that would not be addressed in an acute psychiatric hospital stay meant to stabilize a mental health crisis.

The purpose of PRTF-MI/ID is to engage the youth/guardian/caregiver in addressing clearly identified behavioral health and intellectual/developmental disability challenges and to stabilize symptomology in preparing the youth for a less restrictive environment. There is a particular focus on transferring skills necessary to foster and maintain the outcomes of increased independence, productivity, enhanced family functioning and inclusion in the community.

The goal of PRTF-MI/ID is to create a safe, holistic, consistent, predictable, and therapeutically supportive environment with a comprehensive array of professional treatment services which are designed to maintain a treatment milieu that is functionally relevant to youth, whose significant behavioral health challenges and MI/ID cannot be sufficiently addressed at home or in another non-clinical setting. These services will assist the youth with acquiring, retaining, improving, and generalizing the behavioral, self-help, socialization, and adaptive skills needed to achieve objectives of improved health, welfare, and the realization of individuals' maximum physical, social, psychological, and vocational potential for useful and productive activities in the home and community. Program staff hold professional and experiential competencies in the fields of behavioral health and MI/ID. Staff must also clearly display the capacity to provide appropriate care, supervision, and targeted clinical, behavioral, and self-care interventions to the youth served in these programs.

Youth entering the PRTF program may be referred by a youth's child and family team (CFT) via the youth's OhioRISE Care Management Entity (CME) or Aetna Better Health of Ohio (the OhioRISE Plan) as a result of a youth's inability to be maintained in a lower-intensity community program or lower-level residential program with a reasonable degree of safety. In

situations where a behavioral health psychiatric admission results in connection to the OhioRISE plan, a hospital may make a referral through the Aetna Transition of Care Coordinator.

Clinical Criteria

Admission Criteria

The youth must meet all criteria A through I.

- A. The youth meets the age range for the specific PRTF MI/ID program.
- B. The youth has been determined eligible for services by the county board of developmental disabilities.
- C. The youth presents with symptoms consistent with a DSM 5 behavioral health disorder, as well as a co-occurring intellectual or developmental disability, and requires intensive out-of-home therapeutic intervention.
- D. The youth is in need of 24-hour staff supervision due to emotional and/or behavioral challenges in the home and/or community to such an extent that:
 - The psychological or physical safety of the youth or others is at risk; and/or
 - The youth has been (or is) not able to function in regular community, home, or school activities due to significant symptoms and/or behaviors. The Ohio Children’s Initiatives CANS Assessment and/or other relevant clinical information indicate that the youth’s presenting treatment needs are consistent with PRTF intensity of service.
- E. The youth cannot successfully and safely function in a non-clinical setting or less restrictive setting and requires behavior supports and close supervision. Common behavioral issues may include irritability, emotional outbursts, (often due to anxiety, phobias, and compulsions or at times of transition); oppositional behaviors toward tasks of daily living (tactile sensitivities, comprehension problems); resisting requests to change task or shift from one activity to another. Such challenging/risk taking behaviors may manifest as, but are not limited to:
 - Physical aggression and/or property destruction (possibly due to trauma, poor communication skills, etc.)
 - Low frustration level, social isolation, involvement with negative peer groups, etc., which may result in behavior that leads to juvenile justice involvement, home and school disciplinary issues, psychiatric hospitalization; etc.

	<ul style="list-style-type: none"> • Verbal threats to peers, parents, authority figures, etc. • Problematic sexual behavior (possibly due to lack of insight about boundaries / health relationships, misinterpreted social cues, communication limitations, exposure to sexually explicit material, or sexual abuse victimization) that does not require sex offense specific treatment. • History of substance use that does not require specialized substance use treatment. • Elopement behavior (including AWOL and bolting); • Isolated fire play/setting (low risk); fire setting evaluation is required if fire setting behaviors have occurred within the past 2-year period. • Minor legal infractions (e.g., truancy, curfew, repeated probation violations, etc.) and/or at risk of involvement in the juvenile justice system due to poor judgment and/or impulse control. <p>F. The youth may exhibit receptive and expressive language skills and reasoning skills but may exhibit some impairment in this area.</p> <p>G. Based upon information provided in a completed clinical assessment, the youth exhibits limitations in his/her functional capacity within school, home, and the community.</p> <p>H. The youth presents as able to benefit from the PRTF-MI/ID services, such as the utilization of direct support, skills training, and therapeutic services delivered at this intensity of service.</p> <p>I. As a result of youth’s intellectual/developmental disability and co-occurring behavioral health disorder, the youth is unable to consistently function independently in significant life domains potentially involving: self-care without prompts and limited support, self-direction, capacity for independent living, or economic self-sufficiency. Close supervision, monitoring, and targeted clinical/behavioral intervention are indicated in order to improve the youth’s ability to adequately function and work toward proficiency in the identified functional domains.</p>
<p>Exclusion Criteria</p>	<p>Any of the following is sufficient for exclusion from the PRTF MI/ID intensity of service:</p> <ul style="list-style-type: none"> A. The youth is at imminent risk of causing serious harm to self or others. B. The Ohio Children’s Initiatives CANS Assessment and/or other relevant clinical information indicate that the youth needs a higher

	<p>intensity treatment program or a lower intensity treatment program.</p> <ul style="list-style-type: none"> C. The youth (18 or older) and/or the family/guardian/ caregiver does not voluntarily consent to treatment. D. The youth has a sole diagnosis of an Intellectual/Developmental Disability and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM 5 mental health diagnosis. E. The youth is unable to perform skills of daily living without total supports and requires interventions that go beyond the capability of this setting. F. The youth has a medical condition or impairment that would prevent participation in services and that require daily care that is beyond the capability of this setting. G. The youth has one or more medical conditions that requires treatment by an on-site Registered Nurse/LPN 24-hours a day, including but not limited to: oral or nasal suctioning, intravenous medications, tube feeding, dialysis monitoring, or catheterization. H. The youth requires absolute physical assistance with transfers and mobility. I. The youth’s cognitive functioning falls below a moderately impaired level and the severity of cognitive impairment does not allow him/her to actively participate in this type of milieu and therapeutic intervention.
<p>Continued Stay Criteria (Youth Specific)</p>	<p>All of the following criteria are necessary for continuing treatment at this intensity of service:</p> <ul style="list-style-type: none"> A. The severity of the behavioral/emotional disturbance continues to meet the criteria for the PRTF-MI/ID intensity of service (IOS). B. The Ohio Children’s Initiatives CANS Assessment and/or other relevant information indicate the youth continues to need the PRTF IOS. C. The youth’s treatment does not require a higher Intensity of Service treatment program or a lower Intensity of Service treatment program. D. Services at this Intensity of Service continue to be required to support reintegration of the youth into a less restrictive environment. E. The youth and the parent/guardian/caregiver or other individuals identified by the youth are actively participating in treatment, to the fullest extent possible. F. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved and adjustments in the individual plan of care include strategies for achieving these unmet goals.

	<p>G. There is documented evidence of active, individualized transition planning.</p>
<p>Continued Stay Criteria (PRTF Responsibility)</p>	<p>A. The individual plan of care is appropriate to the youth’s presenting treatment needs, with realistic and specific goals and objectives that include target dates for accomplishment.</p> <p>B. Individualized services and treatments are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.</p> <p>C. When clinically necessary, appropriate psychopharmacological evaluation has been completed and ongoing treatment is initiated and monitored.</p>
<p>Transition Criteria</p>	<p>Please indicate which of the following criteria are met for transition: <i>*Required</i></p> <p>A. *The youth’s documented treatment plan goals and objectives for this intensity of service, as reported in the youth’s individual plan of care, have been met or have documented progress and barriers toward meeting goals.</p> <p>B. *There is documented justification that youth meets the criteria for a higher intensity of service treatment program or a lower intensity of service treatment program.</p> <p>C. *The youth and the youth’s family/guardian/caregiver have been connected with OhioRISE Care Coordination.</p> <p>D. The youth and the parent/guardian/ caregiver are competent but non-participatory in treatment or non-adherent with the treatment program’s rules and regulations. The nonadherence is significant enough to negatively impact the overall treatment course and</p>

	<p>compromises the youth’s ability to have a successful, positive response to treatment.</p> <p>E. There has been limited progress toward treatment goals with no reasonable expectation of progress at this intensity of service, despite attempts to modify and revise the individual plan of care for the benefit of the youth.</p> <p>F. The Ohio Children’s Initiatives CANS Assessment and/or other relevant information indicate that the youth needs a higher intensity treatment program or a lower intensity treatment program.</p> <p>G. Consent for treatment is withdrawn by the family/guardian/ caregiver and/or the youth.</p> <p>H. Young person transitioning from PRTF to independent living, or adulthood, ensure that support systems and specific therapeutic services to maintain stability in a lower level of care have been identified and set up prior to transition.</p> <p>I. A youth’s support systems and specific therapeutic services (which allow the youth to be maintained in a lower Intensity of Service treatment program) have been identified, documented and set up prior to the transition of the youth.</p> <p>J. *A comprehensive transition plan has been developed with family/guardian/caregiver along with the child and family team to include contingency planning to address any significant changes for the youth after transition.</p> <p>K. A comprehensive transition plan with follow-up appointments is in place and the first follow-up appointment will take place within 7 calendar days of transition.</p>
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Provider Training Requirements for PRTF-MI/ID Facilities

PRTF providers serving youth with MI/ID will complete the following DODD and OMHAS-approved trainings prior to working with these youth:

Training for PRTFs Serving Youth with MI/ID			
Training	Leadership	Clinical Staff	Direct Care Staff
Did You Notice? Training for DSPs	X	X	X
Supporting Youth with Intensive and Complex Needs	X (Module 1)	X	X

Autism Spectrum Disorder: ASD Strategies in Action (Evidence-Based Strategies)		X	X
Sensory Differences		X	X
Communication Differences		X	X
Challenging Behavior: Expect Success Training including Evidence-Based Principles		X	X
Recognizing and Responding to Trauma		X	X
Did you Notice? Training for DSPs			X
Introduction to Trauma Informed Care	X	X	X
The Impact of Trauma on Individuals with DD	X	X	X
Building Resilience: 4 Tools to Assist Those We Serve and Ourselves	X	X	X
Growing Resilience	X	X	X
Growing Family Resilience	X	X	X
Future Planning Toward a Meaningful Adult Life	X	X	X
Family Engagement/Partnering with Families	X	X	X
Working as a Team/Effective Communication with Families and Local Partners	X	X	X
Families as Partners in the Secondary Transition Process (ODE)	X		
Effective Coaching and Coaching Techniques	X	X	
State and Local Resources Available to Youth and Families	X	X	
Overview of IDEA, Special Education, IEP	X	X	

Overview of DODD Service and Support for Youth and Adults	X	X	
MI/ID TRAINING SERIES: (OMHAS E-Academy)			
Medical Assessment / BPSD Formulation (45)		X	
Psychotropic Medications in IDD (45)		X	
Basic IDD Knowledge/Pharm for Families/People First Language (45)			X
How to recognize MH in ID/Suicide Prevention in ID (45)		X	X
ID for First Responders/Ohio: A Technology First State (45)			X
Traumatic Brain Injury		X	
Ancillary Services (OT/PT/Speech Therapy/Behavioral Asst-Interventions		X	
Autism Spectrum Disorder		X	
SAMI and SUD/IDD (45)		X	
Gender Diversity and Correlation of GD/ASD (45)		X	X
Trauma in IDD (45)	X	X	X
Mood Disorders in IDD (45)		X	
Anxiety Disorders in IDD (45)		X	
Psychotic Disorders in IDD (45)		X	
Borderline Personality Disorder and Other Personality Disorders (45)		X	X

Aggression in IDD (45)		X	X
IDD for Nurses (45)		X	
IDD for Counselors/Psychotherapists/Adapted Therapy for IDD (45)		X	
Sexual Trauma & Sexual Offending Behavior in IDD (45)		X	X
Working with MI/ID: Best Practices to support those with BPD, Mood d/o, Anxiety d/o (45)		X	
IDD for DSPs/TPWs and Care Coordinators (45)			X
IDD for Services and Supports Administrators/Case Managers (45)			X
Neurologic Disorders in IDD (45)		X	
Traumatic Brain Injury (45)		X	
Legal Issues in IDD (45)	X		

Appendix F: Cross-System Incident Reporting Requirements

CMS	
Incident	Requirement
Suicide (includes attempt)	<p>42 CFR 483.374(b): The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in § 483.352 of this part, and a resident's suicide attempt.</p> <p>(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State-designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.</p> <p>(2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.</p> <p>(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.</p> <p>(c) Reporting of deaths. In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office.</p> <p>(1) Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death.</p> <p>(2) Staff must document in the resident's record that the death was reported to the CMS regional office.</p> <p>(1) Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death.</p> <p>(2) Staff must document in the resident's record that the death was reported to the CMS regional office.</p>
Homicide by Client	
Accidental Death	
Physical Abuse	
Sexual Assault by Non-staff, including a visitor, client or other	
Physical Assault by Non-Staff including Visitor, Client, or Other	
Seclusion/Restraint related Injury to Client	
Seclusion/Restraint related Death	
Natural Death	

OhioMHAS			
Incident	Requirement	Rule Reference	Report Location
Suicide (includes attempt)	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)

OhioMHAS			
Homicide by Client	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Accidental Death	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Physical Abuse	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Sexual Abuse	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Neglect	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Defraud	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Involuntary Termination without Appropriate Client Involvement	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Sexual Assault by Non-staff, including a visitor, client or other	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Physical Assault by Non-Staff including Visitor, Client, or Other	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Medication Error	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)

OhioMHAS			
Adverse Drug Reaction	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Employee Theft of Medication	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Medical Events Impacting Provider Operations	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A (typically for COVID cases or big outbreaks of communicable disease)	Web Enabled Incident Reporting System (WEIRS)
Temporary Closure of One or more Provider Sites	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Inappropriate Use of Seclusion or Restraint	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)

OhioMHAS			
<p>Inappropriate Restraint Techniques and other Use of Force</p> <p>Methods prohibited by OAC 5122-26-16 (D)(2):</p> <ol style="list-style-type: none"> 1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises 2. Any technique that restricts the client's ability to communicate 3. Any technique that obstructs vision 4. Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual's mouth or nose 5. Use of mechanical restraint on a client under age 18 6. A drug or medication that is used as a restraint to control behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's medical or psychiatric condition or that reduces the client's ability to effectively or appropriately interact with the world around him/her 7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers 	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
OhioMHAS			
Seclusion/Restraint related Injury to Client	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Seclusion/Restraint related Death	Per incident within 24 hours of discovery, exclusive of weekends & holidays	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Seclusion	Reported every 6 months in Provider Six Month Report	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)

OhioMHAS			
Mechanical Restraint	Reported every 6 months in Provider Six Month Report	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Physical Restraint excluding Transitional Hold	Reported every 6 months in Provider Six Month Report	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Transitional Hold	Reported every 6 months in Provider Six Month Report	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)
Seclusion/Restraint related Injury to Staff	Reported every 6 months in Provider Six Month Report	OAC 5122-26-13 (F), (G), and Appendix A	Web Enabled Incident Reporting System (WEIRS)

ODM			
Incident	Requirement	Rule Reference	Report Location
Suicide (includes attempt)	<p>PRTF: Take immediate action to ensure the health and welfare of the individual (if attempt). Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p> <p>If attempt results in hospitalization or death</p>	<p>PRTF reports to Aetna OhioRISE</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Unnatural Death or Critical Incident (Suicide Attempt)</p>

ODM			
Homicide by Client	<p>PRTF: Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>42 CFR 483.374(c): Must report death of any resident to the CMS Regional Office by no later than COB the next business day after the resident's death</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Unnatural Death</p>
Accidental Death	<p>PRTF: Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Unnatural Death</p>

ODM			
Physical Abuse	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>
Sexual Abuse	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
Neglect	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Neglect)</p>
Defraud	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident if Misappropriation of > \$500</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Misappropriation)</p>

ODM			
<p>Involuntary Termination without Appropriate Client Involvement</p>	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP)</p>	<p>OAC 5160-44-05: Reportable incident health and welfare is at risk due to loss of housing, etc.</p>	<p>PRTF reports to Aetna</p> <p>Aetna not required to report to ODM at this time</p>
<p>Sexual Assault by Non-staff, including a visitor, client or other</p>	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
<p>Physical Assault by Non-Staff including Visitor, Client, or Other</p>	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>
<p>Medication Error</p>	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP)</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna not required to report to ODM at this time</p>

ODM			
Employee Theft of Medication	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident if Misappropriation of > \$500</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Misappropriation)</p>
Inappropriate Use of Seclusion or Restraint	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
<p>Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint</p>	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>
<p>Seclusion/Restraint related Injury to Client</p>	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
<p>Inappropriate Restraint Techniques and other Use of Force</p> <p>Methods prohibited by OAC 5122-26-16 (D)(2):</p> <ol style="list-style-type: none"> 1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises 2. Any technique that restricts the client’s ability to communicate 3. Any technique that obstructs vision 4. Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual’s mouth or nose 5. Use of mechanical restraint on a client under age 18 6. A drug or medication that is used as a restraint to control behavior or restrict the client’s freedom of movement and is not a standard treatment or dosage for the client’s medical or psychiatric condition or that reduces the client’s ability to effectively or appropriately interact with the world around him/her 7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers 	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner’s office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM’s Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
Seclusion/Restraint related Death	<p>PRTF: Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>42 CFR 483.374(c): Must report death of any resident to the CMS Regional Office by no later than COB the next business day after the resident's death</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Unnatural Death)</p>
Seclusion	<p><u>If physical harm:</u></p> <p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident (if physical harm)</p>	<p><u>If physical harm:</u></p> <p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
Mechanical Restraint	<p><u>If physical harm:</u></p> <p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident (if physical harm)</p>	<p><u>If physical harm:</u></p> <p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>
Physical Restraint excluding Transitional Hold	<p><u>If physical harm:</u></p> <p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident (if physical harm)</p>	<p><u>If physical harm:</u></p> <p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
<p>Transitional Hold</p>	<p><u>If physical harm:</u></p> <p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident (if physical harm)</p>	<p><u>If physical harm:</u></p> <p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>
<p>Seclusion/Restraint related Injury to Staff</p>	<p><u>If non-approved restraint:</u></p> <p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident (if non-approved restraint)</p>	<p><u>If non-approved restraint:</u></p> <p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)</p>

ODM			
Exploitation	<p>PRTF: Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>42 CFR 483.374(c): Must report death of any resident to the CMS Regional Office by no later than COB the next business day after the resident's death</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Exploitation)</p>
Natural Death	<p>PRTF: Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>42 CFR 483.374(c): Must report death of any resident to the CMS Regional Office by no later than COB the next business day after the resident's death</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP) AND Enter in IMS within one business day</p>	<p>OAC 5160-44-05: Critical Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Death)</p>

ODM			
Lost or Missing	<p>PRTF: Ensure immediate action to ensure the health and welfare of the individual. Within 24 hours of discovering the incident, notify the OhioRISE plan or its designee, unless other federal, state, local or professional law require sooner notification</p> <p>Aetna: Ensure immediate action was taken (or take some action within 24 hours), notify appropriate investigative, protective, or regulatory authority entities (may include law enforcement, coroner's office, county DD board, PCSA, APS, long-term care ombudsman; ADAMH Board, ODH or other licensure/cert board or accrediting body; Ohio AG (MCD fraud), local probate court, PCP)</p>	<p>OAC 5160-44-05: Reportable Incident</p>	<p>PRTF reports to Aetna</p> <p>Aetna not required to report to ODM at this time</p>

ODH		
Incident	Requirement	Report Location
Suicide (includes attempt)	No later than close of business the next business day.	Reporting required to Medicaid / All deaths to CMS RO
Homicide by Client	No later than close of business the next business day.	Reporting required to Medicaid / All deaths to CMS RO
Accidental Death	No later than close of business the next business day.	Reporting required to Medicaid / All deaths to CMS RO
Physical Abuse	No later than close of business the next business day.	Reporting required to Medicaid
Sexual Abuse	No later than close of business the next business day.	Reporting required to Medicaid
Neglect	No later than close of business the next business day.	Reporting required to Medicaid

ODH		
Defraud	Incident/Accident log required - Report all serious occurrences	N/A
Involuntary Termination without Appropriate Client Involvement	Incident/Accident log required - Report all serious occurrences	N/A
Sexual Assault by Non-staff, including a visitor, client or other	No later than close of business the next business day.	Reporting required to Medicaid
Physical Assault by Non-Staff including Visitor, Client, or Other	No later than close of business the next business day.	Reporting required to Medicaid
Medication Error	Incident/Accident log required - Report all serious occurrences	N/A
Adverse Drug Reaction	Incident/Accident log required - Report all serious occurrences	N/A
Employee Theft of Medication	Incident/Accident log required - Report all serious occurrences	N/A
Medical Events Impacting Provider Operations	Immediate reporting	BLTCQ@odh.ohio.gov or 614-752-9524
Temporary Closure of One or more Provider Sites	Immediate reporting	BLTCQ@odh.ohio.gov or 614-752-9524
Inappropriate Use of Seclusion or Restraint	No later than close of business the next business day.	Reporting required to Medicaid
Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint	No later than close of business the next business day.	Reporting required to Medicaid

ODH

<p>Inappropriate Restraint Techniques and other Use of Force</p> <p>Methods prohibited by OAC 5122-26-16 (D)(2):</p> <ol style="list-style-type: none"> 1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises 2. Any technique that restricts the client's ability to communicate 3. Any technique that obstructs vision 4. Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual's mouth or nose 5. Use of mechanical restraint on a client under age 18 6. A drug or medication that is used as a restraint to control behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's medical or psychiatric condition or that reduces the client's ability to effectively or appropriately interact with the world around him/her 7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers 	<p>No later than close of business the next business day.</p>	<p>Reporting required to Medicaid</p>
<p>Seclusion/Restraint related Injury to Client</p>	<p>No later than close of business the next business day.</p>	<p>Reporting required to Medicaid</p>
<p>Seclusion/Restraint related Death</p>	<p>No later than close of business the next business day.</p>	<p>Reporting required to Medicaid / All deaths to CMS RO</p>
<p>Seclusion</p>	<p>Log all s/r - report if serious occurrence</p>	<p>N/A</p>

ODH		
Mechanical Restraint	Log all s/r - report if serious occurrence	N/A
Physical Restraint excluding Transitional Hold	Log all s/r - report if serious occurrence	N/A
Transitional Hold	Log all s/r - report if serious occurrence	N/A
Seclusion/Restraint related Injury to Staff	Log all s/r - report if serious occurrence	N/A
Exploitation	No later than close of business the next business day.	Reporting required to Medicaid / All deaths to CMS RO
Natural Death	No later than close of business the next business day.	Reporting required to Medicaid / All deaths to CMS RO
Lost or Missing	Incident/Accident log required - Report all serious occurrences	N/A

Aetna	
Incident	Report Location
Suicide (includes attempt)	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Homicide by Client	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Accidental Death	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Physical Abuse	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Sexual Abuse	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Aetna	

Neglect	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Defraud	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Involuntary Termination without Appropriate Client Involvement	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Sexual Assault by Non-staff, including a visitor, client or other	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Physical Assault by Non-Staff including Visitor, Client, or Other	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Medication Error	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Employee Theft of Medication	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Inappropriate Use of Seclusion or Restraint	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
<p>Inappropriate Restraint Techniques and other Use of Force</p> <p>Methods prohibited by OAC 5122-26-16 (D)(2):</p> <ol style="list-style-type: none"> 1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises 2. Any technique that restricts the client's ability to communicate 3. Any technique that obstructs vision 4. Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual's mouth or nose 5. Use of mechanical restraint on a client under age 18 6. A drug or medication that is used as a restraint to control behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's medical or psychiatric condition or that reduces the client's ability to effectively or appropriately interact with the world around him/her 7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers 	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.

Aetna	
Seclusion/Restraint related Injury to Client	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Seclusion/Restraint related Death	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Seclusion	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Mechanical Restraint	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Physical Restraint excluding Transitional Hold	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Transitional Hold	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Seclusion/Restraint related Injury to Staff	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Exploitation	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Natural Death	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.
Lost or Missing	Send an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.

ODJFS		
Incident	Requirement	Report Location
Suicide (includes attempt)	5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of a critical incident within twenty-four hours and complete the critical incident report within one business day.	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours

ODJFS		
Homicide by Client	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of a critical incident within twenty-four hours and complete the critical incident report within one business day.</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours</p>
Accidental Death	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of a critical incident within twenty-four hours and complete the critical incident report within one business day.</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours</p>
Physical Abuse	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day. (C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours. Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>
Sexual Abuse	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day. (C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours. Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>

ODJFS		
Neglect	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>(C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p> <p>Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>
Defraud	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p>
Sexual Assault by Non-staff, including a visitor, client or other	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>(C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p> <p>Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>
Physical Assault by Non-Staff including Visitor, Client, or Other	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>(C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p> <p>Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>

ODJFS		
Medication Error	5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.
Adverse Drug Reaction	5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.
Employee Theft of Medication	5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.
Medical Events Impacting Provider Operations	5101.2.9.02 (J) Each residential facility shall have a written work schedule including provisions for use of relief staff and a backup plan for emergency relief staff.	No Reporting Required
Temporary Closure of One or more Provider Sites	5101.2.5.13.1 requires a disaster plan which addresses what will happen if the site is uninhabitable. 5101.2.5.02(I)(3) requires immediate notification to any agency with children in placement and ODJFS. After relocating, an amendment request must be made to ODJFS.	JFS 1290 Application for Certification of Agency Functions (for the amendment)
Inappropriate Use of Seclusion or Restraint	5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day. (C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours. Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report

ODJFS		
<p>Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint</p>	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day. (C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours. Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>
<p>Inappropriate Restraint Techniques and other Use of Force</p> <p>Methods prohibited by OAC 5122-26-16 (D)(2):</p> <ol style="list-style-type: none"> 1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises 2. Any technique that restricts the client’s ability to communicate 3. Any technique that obstructs vision 4. Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual’s mouth or nose 5. Use of mechanical restraint on a client under age 18 6. A drug or medication that is used as a restraint to control behavior or restrict the client’s freedom of movement and is not a standard treatment or dosage for the client’s medical or psychiatric condition or that reduces the client’s ability to effectively or appropriately interact with the world around him/her 7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or 	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day. (C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours. Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>

electronic restraint devices such as stun guns and tasers		
ODJFS		
Seclusion/Restraint related Injury to Client	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>(C) Notification of abuse within a residential facility requires immediate reporting when abuse/neglect is known or suspected</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p> <p>Report of known or suspected abuse/neglect is documented In SACWIS by the PCSA receiving the report</p>
Seclusion/Restraint related Death	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of a critical incident within twenty-four hours and complete the critical incident report within one business day.</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours</p>
Seclusion	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>5101:2-9-22 outlines the allowed use of physical restraint, isolation, and seclusion.</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p>
Mechanical Restraint	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>5101:2-9-22 outlines the allowed use of physical restraint, isolation, and seclusion.</p> <p>5101:2-9-21 Prohibits the use of mechanical restraint.</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p>
Physical Restraint excluding Transitional Hold	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>5101:2-9-22 outlines the allowed use of physical restraint, isolation, and seclusion.</p>	<p>Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.</p>

ODJFS		
Transitional Hold	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of critical incidents within twenty-four hours and complete the critical incident report within one business day.</p> <p>5101:2-9-22 outlines the allowed use of physical restraint, isolation, and seclusion.</p>	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours.
Exploitation	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of a critical incident within twenty-four hours and complete the critical incident report within one business day.</p>	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours
Natural Death	<p>5101.2.9.23 Notification and Documentation of Critical Incidents - Requires notification of a critical incident within twenty-four hours and complete the critical incident report within one business day.</p>	Critical Incident Report to the individual or agency which placed the child and person or agency holding custody within 24 hours

State Protection and Advocacy Agency - Disability Rights Ohio (DRO)		
Incident	Requirement	Report Location
Suicide (includes attempt)	Report same incidents reported to OhioMHAS	<p>Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org</p> <p>SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission</p> <p>Attn: Amy Price, Associate Advocacy Director</p>
Homicide by Client	Report same incidents reported to OhioMHAS	<p>Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org</p> <p>SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission</p> <p>Attn: Amy Price, Associate Advocacy Director</p>
Accidental Death	Report same incidents reported to OhioMHAS	<p>Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org</p> <p>SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission</p>

		Attn: Amy Price, Associate Advocacy Director
DRO		
Physical Abuse	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Sexual Abuse	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Neglect	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Defraud	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Involuntary Termination without Appropriate Client Involvement	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Sexual Assault by Non-staff, including a visitor, client or other	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director

DRO		
Physical Assault by Non-Staff including Visitor, Client, or Other	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Medication Error	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Adverse Drug Reaction	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Employee Theft of Medication	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Medical Events Impacting Provider Operations	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Temporary Closure of One or more Provider Sites	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director

DRO		
Inappropriate Use of Seclusion or Restraint	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Seclusion/Restraint related Injury to Client	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Seclusion/Restraint related Death	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Seclusion	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director

DRO		
<p>Inappropriate Restraint Techniques and other Use of Force</p> <p>Methods prohibited by OAC 5122-26-16 (D)(2):</p> <ol style="list-style-type: none"> 1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises 2. Any technique that restricts the client’s ability to communicate 3. Any technique that obstructs vision 4. Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual’s mouth or nose 5. Use of mechanical restraint on a client under age 18 6. A drug or medication that is used as a restraint to control behavior or restrict the client’s freedom of movement and is not a standard treatment or dosage for the client’s medical or psychiatric condition or that reduces the client’s ability to effectively or appropriately interact with the world around him/her 7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers 	<p>Report same incidents reported to OhioMHAS</p>	<p>Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org</p> <p>SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission</p> <p>Attn: Amy Price, Associate Advocacy Director</p>
<p>Mechanical Restraint</p>	<p>Report same incidents reported to OhioMHAS</p>	<p>Facility may submit either by fax: 614-644-1888 or email: mhir@disabilityrightsohio.org</p> <p>SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission</p> <p>Attn: Amy Price, Associate Advocacy Director</p>

DRO		
Physical Restraint excluding Transitional Hold	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Transitional Hold	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Seclusion/Restraint related Injury to Staff	Report same incidents reported to OhioMHAS	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director
Natural Death	CFR requires notification	Facility may submit either by fax: 614-644-1888 <i>or</i> email: mhir@disabilityrightsohio.org SUBJ: Disability Rights Mental Health/PRTF Incident Report Submission Attn: Amy Price, Associate Advocacy Director

Appendix G: Aetna Better Health of Ohio's Encounters, Billing, and Claims Guidance

Provider Network Management (PNM) System Overview

Under Ohio Next Generation of Managed Care, the introduction of Provider Network Management System was developed to help providers, managed care organization and entities (MCEs), and Ohio Department of Medicaid (ODM) to improve data exchanges. The new system will replace the current MITS system and provider portal. The PNM module serves as the single-entry point for secure portal functions such as claims submissions, prior authorizations, and member eligibility verification. For more information, please refer to:

<https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing>

Overview

Aetna Better Health of Ohio processes claims for covered services provided to members in accordance with applicable policies and procedures, and in compliance with applicable state and federal laws, rules, and regulations. On February 1, 2023 the Fiscal Intermediary (FI) began processing of claims via [the Electronic Data Interchange \(EDI\)](#). Fee-for-service claims submitted to the EDI are processed, adjudicated, and paid by the FI. Managed care claims submitted via the EDI will be routed to the MCOs for processing, adjudication, and payment. Additional FI functionality will come later related to portal claims submitted via the PNM portal. Providers, trading partners, and managed care entities will not directly interact with the FI.

Billing Encounters and Claims Overview

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the claim processing system.

When to Bill a Member

All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing.

- A member may be billed only when the member knowingly agrees to receive non-covered services under the OhioRISE plan.
- Provider MUST notify the member in advance that the charges will not be covered under the program.

- Provider MUST have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

When to File a Claim

All claims are to be submitted electronically to through the ODM Fiscal Intermediary/EDI using the Payer ID#: 45221. Before submitting a claim through your clearinghouse, please make sure your clearinghouse is compatible with the FI.

Clean Claims

We require clean claim submissions for processing. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

Participating Providers:

- New Claim Submissions – Please consult your contract for your contractual timely filing limit for new claims. For hospital inpatient claims, date of service means the date of discharge of the member.
- Claim Disputes and Resubmissions – Please consult your contract for your contractual timely filing limit for disputes and corrected claims. For hospital inpatient claims, date of service means the date of discharge of the member.

Non-Participating Providers New Claim Submissions:

- Claim submissions must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.
- Claim Disputes and Resubmissions – Claim disputes and corrected claims must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

How to File a Claim

Beginning February 1, 2023, all claims submitted by trading partners, with dates of service on and after February 1 must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the health plan for processing and payment.

Injuries Due to an Accident

Medicare and Medicaid laws only permit subrogation in cases where there is a reasonable expectation of third-party payment. In cases where legally required insurance (i.e., auto-liability) is not actually in force, we are required to assume responsibility for primary payment.

Important Points to Remember

We do not accept direct Electronic Data Interchange (EDI) submissions from our providers. We do not perform any 837 testing directly with our providers but perform such testing with Change Healthcare.

Correct Coding Initiative

We follow the same standards as Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

We utilize ClaimsXten as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based, stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimsXten. It enables us to share with our providers, the claim auditing rules, and clinical rationale inherent in ClaimsXten.

Providers will have access to Clear Claim Connection through our website (<https://www.aetnabetterhealth.com/ohiorise/index.html>) and a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim, so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure.
- Are necessary to accomplish the comprehensive procedure.
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- “Unbundling” - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

Modifiers

In order to communicate detailed information in an efficient, standardized way, modifiers are two character suffixes that healthcare providers or coders attach to a CPT or HCPCS code to provide additional information about the practitioner or procedure. It is extremely important to accurately report modifiers as they are used to count towards soft limits, price services, and adjudicate claims. Procedure modifiers designated to practitioner type and licensure level are required for OhioRISE in order to describe specific circumstances and align appropriate rate pricing.

Applicable behavioral health provider type and specialty modifiers can be found in the Provider Requirements and Reimbursement Manual. Please see this reference for more information: https://bh.medicaid.ohio.gov/Portals/0/2-1-2022%20BH%20Manual%20FV%201_21.pdf

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website <http://www.aetnabetterhealth.com/Ohio/> or by calling the Claims Inquiry Claims Research (CICR) Department **1-833-711-0773 (option 2)**.

Online Status Through the Secure Web Portal

We encourage providers to take advantage of using online status, as it is quick, convenient, and can be used to determine status for multiple claims.

Provider Experience

The Provider Experience Department:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
 - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
 - Excludes rebilling a claim (the entire claim must be resubmitted with corrections). Please be prepared to give the service representative the following information:
 - Provider name or NPI number with applicable suffix if appropriate.
 - Enrollee name and enrollee identification number.
 - Date of service.
 - Claim number from the remittance advice on which you have received payment or denial of the claim.

Payment in Full Information

The OhioRISE payment for any covered services constitutes payment in full and OhioRISE will ensure its subcontractors do not charge members, their custodians, or ODM any additional co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.

Payment of Claims

We process claims and notify providers of outcomes using a remittance advice. Providers may choose to receive checks through the mail or electronically. We encourage providers to take advantage of receiving Electronic Remittance Advices (ERA), which are received much sooner than remittance advice received through the mail, enabling you to post payments sooner.

Beginning February 1, 2023, all managed care claims submitted by trading partners, with dates of service on and after February 1 must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the selected MCEs for processing and payment.

Providers who submit managed care claims through direct data entry (DDE) will do so via the appropriate managed care portal. Aetna will conduct the usual adjudication of the claim.

Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. We encourage you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. Payment from the OhioRISE plan will be made on separate check. Aetna Better Health is partnering with Change Healthcare to introduce the new EFT

Registration Services (EERS), a better and more streamlined way for our providers to access payment services.

EERS will offer providers a standardized method of electronic payment while also expediting the payee enrollment and verification process. Providers will be able to use the Change Healthcare tool to manage EFT with multiple payers on a single platform.

EERS will give payees multiple ways to set up EFT in order to receive transactions from multiple payers. If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.

Providers who currently use Change Healthcare as a clearinghouse will still need to complete EERS enrollment, but providers who currently have an application pending with Change Healthcare will not need to resubmit. Once enrolled, payees will have access to the Change Healthcare user guide to aid in navigation of the new system.

How and When Do I Enroll?

All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit <https://payerenrollservices.com/>.

For questions or concerns, please reach out to your Aetna Provider Network team or visit the [Change Healthcare FAQ page](#).

Claim Resubmission

Non-participating providers have 365 days from the date of service to resubmit a revised version of a processed claim. Participating providers should refer to their contract for timely filing and resubmission timeframes. The review and reprocessing of a claim do not constitute a reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Resubmissions must be submitted electronically with a frequency code of 7 or 8.

Instruction for Specific Claim Types

General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your Provider Agreement. Prior authorized services from non-participating health providers will be paid in accordance with Medicaid claim processing rules.

Same Day Readmission

Providers submitting claims for inpatient facilities should use the CMS 1450 electronic format.

There may be occasions where a member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with twenty-four (24) hours of discharge. For example: Discharge Date: 10/2/20 at 11:00 a.m. / Readmission Date: 10/3/20 at 9:00 a.m.

Since the readmission was within twenty-four (24) hours, this would be considered a same day readmission per above definition.

Provider Remittance Advice

We generate checks weekly. Claims processed during a payment cycle will appear on a remittance advice (“remit”) as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to make certain proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Providers who are interested in receiving electronic remittance advices from the new EDI will need to sign up. Providers must have enrolled using the ODM-06306 835 designation form which is located [Authorized Trading Partners \(ohio.gov\)](#). By using this form, providers will receive all 835 electronic remittance advices (ERA) from all payers, i.e., Change Healthcare and MCEs. The PDF versions of the remittance advices from all payers will be available via the PNM portal.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Ohio for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment, depending on the terms of the Provider Agreement.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Ohio due to overpayment.

- Reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of “REVERSED” in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Ohio after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically, then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed, along with the last four digits of the bank account to which the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number. The Claim Header area of the remit lists information pertinent to the entire claim. This includes:

- Member Name
- ID
- Birth Date
- Account Number
- Authorization ID, if obtained
- Provider Name
- Claim Status
- Claim Number
- Refund Amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.

The Message at the end of the remit contains claims inquiry and resubmission information, as well as grievance rights information.

An electronic version of the Remittance Advice can be obtained. In order to qualify for Electronic Remittance Advice (ERA), you must currently submit claims through Electronic Data Interchange (EDI) submissions and receive payment for claim by Electronic Funds Transfer (EFT). You must also have the ability to receive ERA through 835 files. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to

receive payment and reconcile your outstanding accounts. Please contact our Provider Experience Department for assistance with this process.

Encounter Data Management (EDM) System

Aetna Better Health of Ohio uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to the Ohio Department of Medicaid (ODM) requirements. The EDM System also warehouses encounter data from vendors and formats it for submission to the ODM. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness, and we then submit encounter data to the ODM. Our EDM System processes CMS1500, UB04 (or UB92 claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-10, CPT-4, HCPCS-I, II). Our Provider Agreements require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements. Part of our encounter protocol is the requirement for providers to utilize National Drug Code (NDC) coding in accordance with the ODM's requirements.

The EDM System has top-of-the-line functionality to track encounters accurately and consistently throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to electronically accept a HIPAA compliant 837 (I and/or P) electronic claim transaction, 835 Claim Payment/Advice transaction, and the National Council for Prescription Drug Programs (NCPDP) transaction in standard format. We require our providers and their clearinghouses to send electronic claims in these formats. We collect claims information from multiple data sources into the EDM System for processing, including data from our claims adjudication system, as well as data from third-party vendors under contract to process various claims. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Encounter Data

Aetna Better Health requires the submission of all processed claims data for encounter data collection by the State of Ohio. Failure to follow the same standards as the Correct Coding Initiative (CCI) will result in a claims payment denial.

Claims Processing

Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EDM System. Our Encounter Management Unit validates the receipt of all the business application system

claims data into EDM System using a transfer validation report. The Encounter Management Unit research, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Another critical step in our encounter data correction process is the encounter error report. We generate this report upon receipt of response files from ODM and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. This data facilitates the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

Appendix H: Aetna Better Health of Ohio's Non-Discrimination Notice

Aetna Better Health® of Ohio follows state and federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, sex, gender identity, sexual orientation, religion, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, or geographic location.

If you would like to file a complaint, please contact Aetna Better Health by either:

Mail:

Aetna Better Health
7400 W Campus Rd, Suite 200
New Albany, OH 43054

Phone:

1-833-711-0773 (TTY: 711)

Email: OhioRISEMemberServices@Aetna.com

If you would like to file a complaint with Health and Human Services Office for Civil Rights, please go to <https://ocrportal.hhs.gov/ocrsmartscreen/main.jsf> or by mail or phone at:

Mail:

U.S. Department of Health and Human Services
200 Dependence Avenue, S.W.
Washington, D.C. 20201

Phone:

1-800-368-1019, TDD: 1-800-537-7697

Language Assistance, Interpretation Services, and Auxiliary Aids

ENGLISH: To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to, oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling Aetna Better Health Member Services at **1-833-711-0773 (TTY: 711)**

SPANISH: Para ayudarle a entender este aviso, disponemos de asistencia lingüística, servicios de interpretación y ayudas y servicios auxiliares si los solicita, sin costo alguno para usted. Los servicios disponibles incluyen, entre otros, traducción oral, traducción escrita y ayudas auxiliares. Puede solicitar estos servicios o ayudas auxiliares llamando al Departamento de Servicios para Miembros de Aetna Better Health al **1-833-711-0773 (TTY: 711)**.

NEPALI: यो सूचना तपाईंलाई बुझ्न सहायता गर्न तपाईंको निम्न श्रेणीमा आग्रह गर्नुभए अनुसार भाषाको सहायता, अनुवादका सेवाहरू र थप सहायता र सेवाहरू उपलब्ध छन्। समावेश भएका सेवाहरू उपलब्ध छन् तर मौखिक अनुवाद, लिखित अनुवाद र थप सहायतामा सीमित छैनन्। तपाईंले **1-833-711-0773 (TTY: 711)** मा Aetna Better Health सँग सेवाहरूमा फोन गरेर यी सेवाहरू र/वा थप सहायता आग्रह गर्न सक्नुहुन्छ।

مساعدتك في فهم هذا الإخطار، تتوفر المساعدة اللغوية وخدمات الترجمة الفورية والمساعدات والخدمات المعينة عند الطلب مجاناً. تشمل الخدمات

المتاحة، على سبيل المثال لا الحصر، الترجمة الشفوية والترجمة الكتابية والمساعدات المعينة. يمكنك طلب هذه الخدمات و
أو المساعدات

(TTY: 711) على الرقم 833-1—711- 0773 Aetna Better Health الإضافية عن طريق الاتصال بخدمات أعضاء

SOMALI: Si lagaaga caawiyo fahanka ogaysiiskan, kaalmada luqadda, adeegyada turjumaada hadalka ah, iyo qalabka kaalmada naafada iyo adeegyada waxaa la heli karaa marka la codsado iyagoon kharash kugu taagnayn adiga. Adeegyada la heli karo waxaa ku jira, laakiin kuma xadidna, turjumaada hadalka, turjumaada qoran, iyo qalabka kaalmada naafada. Waxaad codsan kartaa adeegyada iyo/ama qalabka kaalmada naafada addoo soo wacaya Adeegyada Xubinta Aetna Better Health lambarka **1-833-711-0773 (TTY: 711)**

RUSSIAN: Если вам нужна помощь в понимании данного уведомления, вы можете обратиться за языковой поддержкой, услугами устного перевода, а также вспомогательными средствами и услугами, которые по запросу оказываются бесплатно. Доступные услуги включают, помимо прочего, устный перевод, письменный перевод и вспомогательные средства. Вы можете обратиться за данными услугами и/или вспомогательными средствами в отдел обслуживания участников Aetna Better Health по телефону **1-833-711-0773 (TTY: 711)**

FRENCH: Pour vous aider à bien comprendre cet avis, vous pouvez faire appel à des services gratuits d'interprétation et d'aide auxiliaire. Par exemple, vous pouvez vous faire traduire un texte par oral ou par écrit, ou encore bénéficier d'autres services auxiliaires. Pour solliciter ces services et/ou une aide auxiliaire, appelez le service réservé aux membres Aetna Better Health au **1-833-711-0773 (TTY: 711)**

VIETNAMESE: Để giúp quý vị hiểu thông báo này, hỗ trợ ngôn ngữ, dịch vụ thông dịch, và các dịch vụ và hỗ trợ phụ trợ được cung cấp miễn phí theo yêu cầu cho quý vị. Các dịch vụ có sẵn bao gồm, nhưng không giới hạn, dịch nói, dịch văn bản và các hỗ trợ phụ trợ. Quý vị có thể yêu cầu các dịch vụ này và/hoặc hỗ trợ phụ trợ bằng cách gọi cho Dịch vụ Hội viên của Aetna Better Health theo số **1-833-711-0773 (TTY: 711)**

SWAHILI: Ili kukusaidia kuelewa ilani hii, usaidizi wa lugha, huduma za ukalimani na vifaa vya kusikia na huduma zinapatikana ukiomba bila malipo yoyote. Huduma hizi ni pamoja na, bila kuishia kwa hizi tu, tafsiri ya mdomo, tafsiri ya maandishi na vifaa vya kusikia. Unaweza kuomba huduma hizi na/au vifaa vya kusikia kwa kupigia simu Aetna Better Health Member Services kwa nambari **1-833-711-0773 (TTY: 711)**

UKRANIAN: Щоб допомогти вам зрозуміти це повідомлення, за запитом вам безкоштовно може надаватися мовна допомога, послуги перекладу, а також допоміжні засоби й послуги. Такі послуги включають, крім іншого, усний переклад, письмовий переклад та допоміжні засоби. Ви можете замовити ці послуги та/або допоміжні засоби, зателефонувавши в службу підтримки учасників Aetna Better Health за номером **1-833-711-0773 (TTY: 711)**

CHINESE (TRADITIONAL): 為幫助您理解本通知，我們可應您的要求免費提供語言協助、口譯服務以及輔助設備和服務。提供的服務包括但不限於口譯、筆譯以及輔助設備。您可致電 Aetna Better Health 會員服務部，要求獲得這些服務和/或輔助設備，電話號碼為：**1-833-711-0773 (TTY: 711)** __ **KINYARWANDA:** Kugira ngo ufashwe gusobanukirwa neza iri tangazo, ubufasha mu by'ururimi, serivisi z'ubusemuzi n'ibikoresho bifasha abafite ubumuga bwo kutumva na serivisi bijyanye biboneka bisabwe kandi nta mafaranga wishyuzwa. Serivisi ziboneka harimo, ariko ntabwo zigarukira gusa ku, busemuzi, ubusemuzi bw'inyandiko n'ibikoresho bifasha abafite ubumuga bwo kutumva. Ushobora gusaba izo serivisi cyangwa

ibikrosho bifasha abafite ubumuga bwo kutumva uhamagaye Aetna Better Health Member Services kuri **1-833-711-0773 (TTY: 711)**

CHINESE (SIMPLIFIED): 为帮助您理解本通知，我们可应您的请求免费提供语言援助、口译服务以及辅助设备和服务。提供的服务包括但不限于口译、笔译以及辅助设备。您可致电 Aetna Better Health 会员服务部，请求获得这些服务和/或辅助设备，电话号码为：**1-833-711-0773 (TTY: 711)**

په دې خبرتیا د پوهیدو په برخه کې ستاسو سره د مرستې لپاره، د غوښتنې په صورت کې د ژبې اړوند مرسته، د ژباړې خدمتونه، او مرستندویه کومکونه او خدمتونه پرته له کوم لګښت څخه شتون لري. په شته خدمتونو کې شفاهي ژباړه، لیکلي ژباړه، او مرستندویه کومکونه د غړو خدمات ته په 1-833-711-0773 Aetna Better Health شامل دي، خو تر دې پورې محدود ندي. تاسو کولی شئ د **0773 (TTY: 711)**

تلیفون کولو سره د دې خدماتو او/یا فرعي مرستو غوښتنه وکړئ

AMHARIC: ይህን ማሳሰቢያ እንዲረዱት ሊያግዝዎ የሚያስችሉ የቋንቋ እርዳታ፣ የትርጉም አገልግሎቶች፣ እና ተያያዥ ድጋፎች እና አገልግሎቶች ሲጠይቁ እርስዎ ምንም ወጪ ሳያወጡ ማግኘት ይችላሉ። ያሉት አገልግሎቶች የቃል ትርጉም፣ የጽሁፍ ትርጉም፣ እና ተያያዥ ድጋፎች እና ሌሎችን ይጨምራል። እነዚህን አገልግሎቶች እና/ወይም ተያያዥ ድጋፎችን ወደ Aetna Better Health የአባል አገልግሎቶች በ **1-833-711-0773 (TTY: 711)** በመደወል መጠየቅ ይችላሉ።

GUJARATI: આ સૂચનાને સમજવામાં તમારી મદદ કરવા માટે, ભાષા સહાય, દુભાષિયા સેવાઓ અને વધારાની સહાય અને સેવાઓ વિનંતી કરવા પર તમારા માટે કોઈપણ ખર્ચ વિના ઉપલબ્ધ છે. ઉપલબ્ધ સેવાઓમાં મૌખિક અનુવાદ, લેખિત અનુવાદ અને વધારાની સહાયનો સમાવેશ થાય છે, પરંતુ સેવાઓ એટલા સુધી મર્યાદિત નથી. તમે Aetna Better Health Member Servicesને **1-833-711-0773 (TTY: 711)** પર કોલ કરીને આ સેવાઓ અને/અથવા વધારાની સહાયની વિનંતી કરી શકો છો.