# The Network Inclusion Criteria Standards for Excellence

## Philadelphia Department of Behavioral Health and Intellectual disAbility Services

Arthur C. Evans Jr., Ph.D., Commissioner

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# Network Inclusion Criteria
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Dear Stakeholders:

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is taking a holistic approach to the transformation of behavioral health care.  The *Practice Guidelines for Recovery and Resilience Oriented Treatment* are intended to assist agencies in the implementation of services and supports that promote resilience, recovery, and wellness in children, youth, adults, and families.  DBHIDS is making changes to fiscal, policy, regulatory, and community contexts to support the implementation of recovery and resilience oriented health related services.

Transforming the existing credentialing process, or the policies and procedures that are used to assess provider agencies, is necessary to improve quality care, align with national health care reform, and to make regulatory policies consistent with the principles and values promoted by the system.  The existing credentialing process consists of staff file reviews, the review of policies and procedures as well as the review of clinical documentation; however, the inclusion in the DBHIDS network *will* include a much more in-depth and balanced approach with the use of the Network Inclusion Criteria.

The enclosed *Network Inclusion Criteria (NIC)* are the core capabilities that a provider will need to demonstrate in order to be recognized as part of the DBHIDS network regardless of funding stream.  These core capabilities will apply to all behavioral health and substance use services for children, youth, families, and adults, as well as all levels of care.

The content of this document builds on the collective work and ideas of many stakeholders throughout the system, Philadelphia's transformation efforts over the past 30 years, exciting national trends in healthcare reform, and best practices in behavioral health.

The *Network Inclusion Criteria* will begin the first phase of implementation in 2013.  As part of the implementation process we will be encouraging ongoing feedback to help us advance the content in this document.  We look forward to this collaborative process.


Sincerely,



Arthur C. Evans, Ph.D.

# SECTION I:  OVERVIEW

## Vision of Network Excellence

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is committed to ensuring individual and community health and wellbeing.  A high quality network of care that ensures access to services, provides effective, individualized and holistic care, and promotes community support and mobilization is essential to achieve this aim.  The *Network Inclusion Criteria (NIC)* outlined in this document is viewed as a set of core capabilities that a provider shall demonstrate in order to be approved for and maintained in the DBHIDS network of care.  These core capabilities apply to:  1) all behavioral health and substance use services for children, youth, families and adults; 2) all levels of care; and 3) all funding mechanisms across the DBHIDS.  This document provides the essential detail that will assist the provider community in understanding the standards, practices and scoring to be used in the process.

## Philadelphia Behavioral Health Services Transformation

The *Network Inclusion Criteria* builds upon the ambitious transformation of provider concepts, practices and contexts by bringing the systems transformation process and various innovations to the internal operations of DBHIDS and their relationship to agencies and the community at large.  The Network Inclusion Criteria proceed from DBHIDS groundbreaking transformation planning efforts to date, including:

1. *Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change (2006)*.  This paper articulates the values, definitions, and methods by which the Philadelphia transformation would launch, evolve and be sustained.

2. The *Practice Guidelines for Recovery and Resilience-Oriented Treatment, referred to as the Practice Guidelines,* is a product of the partnership with people receiving services, agencies, the community and DBHIDS and are intended to assist in the implementation of services and supports that promote resilience, recovery and wellness in children, youth, adults, and families*.

3. In 2011 the Department launched the *Performance Improvement Process (PIP), now called the Network Improvement and Accountability Collaborative (NIAC),* to ensure that all DBHIDS site visits were driven by the *Practice Guidelines* and conducted in an integrated, strength-based and comprehensive manner.

## The Network Improvement and Accountability Collaborative

The Network Improvement and Accountability Collaborative (NIAC) builds upon this legacy by establishing its fundamental role in creating and sustaining a high quality network of care.  NIAC, through the use of the NIC, will determine the degree to which providers are aligned with the *Practice Guidelines.*  The DBHIDS vision for this effort includes an emphasis on the following:

- Transformation and ongoing improvement of care for people receiving services;
- Establishment of an accountability partnership among people receiving services, DBHIDS, providers and other stakeholders that is designed to:
  - Identify the strengths and challenges of provider performance through a variety of methods including data, observation, interviews with individuals in services, family members, and staff, and other information gained through engagement in the service delivery environment;
  - Develop solutions to system level issues shared across the provider community;
  - Inform the development of needed programs; and,
  - Identify providers who are demonstrating exceptional practice.

The Network Improvement and Accountability Collaborative will pursue this vision. DBHIDS views the pursuit of excellence as a shared effort among all stakeholders including people seeking and receiving series, agencies, and the DBHIDS as well as the community. This "collaborative" effort is critical in shaping future practices, is driven by the *Practice Guidelines* and operationalized in these *Network Inclusion Criteria that*:

- Establish the vision for behavioral healthcare that is sought;
- Identifies the provider standards that align with this vision; and
- Implements a method by which providers and the DBHIDS can determine the quality of care and the improvements necessary in creating excellence in the system.

Providers will have the opportunity and responsibility to fully partner in this process, given that the completion of a criteria-driven *Self-Appraisal* functions as the first step in the review process. The DBHIDS is advancing beyond what it traditionally considered "credentialing" to a much broader approach to *Practice Guideline* alignment as it continues to transform to a recovery/resilience-oriented system of care. Transforming the methods by which DBHIDS engages in network accountability and performance improvement includes creating a coherent, integrated approach that:

- Builds on program strengths;
- Employs recovery/resilience informed criteria to determine quality;
- Seeks to reinforce the aim of helping people with behavioral health challenges to attain optimum results from their engagement with DBHIDS services;
- Streamlines the analysis of provider-level performance measurement within DBHIDS;
- Integrates with pay for performance;
- Aligns with healthcare reform; and,
- Eliminates both the duplication of effort in the DBHIDS and multiple onsite reviews at provider organizations.

## The Network Inclusion Criteria Domains and an Organizational Focus

Using the framework and values from the *Practice Guidelines*, the DBHIDS has organized the Network Inclusion Criteria by an introduction section, entitled the *Foundations of Excellence in Service Delivery*, and the four practice domains. The introductory section focuses on the organization rather than a program or level of care specific focus. A focus on the *Foundations of Excellence in Service Delivery* provides NIAC the opportunity to clearly attend to this important area of program functioning. The four NIC *domains* are identical to the four domains of the *Practice Guidelines*. The sections of the NIC are:

Foundations of Excellence in Service Delivery
Domain 1:   Assertive Outreach and Initial Engagement
Domain 2:   Screening, Assessment, Service Planning and Delivery
Domain 3:   Continuing Support and Early Re-Intervention
Domain 4:   Community Connection and Mobilization

# SECTION II: NIC REVIEW PROCESS AND SCORING

This section outlines the review process, the measurement of *standards* and *practices*, as well as recognition levels and scoring. As stated above, NIAC determines the degree of provider practice alignment with the Network Inclusion Criteria. The DBHIDS will engage in a structured, collaborative review process to assess with providers the degree of such alignment with the *domains*, *standards* and associated *practices* including a focus on the *Foundations of Excellence in Service Delivery* using the scoring methods outlined in this document. The process and the instrument are designed to capture the relevant scoring of practices as well as narrative information on each practice. Prior to the NIAC review agencies will complete a *Self-Appraisal* based on the NIC. Steps of the review process include:

1. Agency notification
2. Completion and submission of the agency *Self-Appraisal* to DBHIDS
3. Schedule coordination and preparation for the site visit
4. Site visit preparation at DBHIDS and the agency
5. Site visit (DBHIDS and the agency collaborate to identify program strengths, solutions to program challenges and the development of the *performance improvement plan*)
6. Analysis, report completion, determination of next steps and corresponding recognition level(s)

## Structure of NIC Domains and Organizational Focus: Standards and Associated Practices

The quality and content of agency practices are determined though a variety of NIAC onsite activities. These may include, but are not limited to, program tours, focus groups, clinical record reviews, peer discussion groups and the review of policies and procedures **(see *Appendix D for the Information Source Key)*. Agency NIC practices are ranked using a 0, 1, 2, 3-point scoring system. Each *Practice* within each *Standard* will be scored using this scale. The *Foundations of Excellence in Service Delivery* as well as the four *Domains* detailed in Section III, includes the following structure, nomenclature and meaning:

- **Organizational Focus (The Foundations of Excellence in Service Delivery) Plus Domains**: There is one (1) *organizational focus* area (The *Foundations of Excellence in Service Delivery*) and a total of four (4) *Domains*. The four *domains* are identical to the four *domains* of the DBHIDS *Practice Guidelines* in content. The *Foundations of Excellence in Service Delivery* focuses on practices associated with agency organizational functioning. Taken together, these five areas represent the full scope of the DBHIDS vision of recovery/resilience-oriented care.

- **Standard:** A standard describes a major sub-section of program performance. The four (4) *domains* and the initial *organizational* section are comprised of thirteen (13) *standards*.

- **Objective:** The objective defines each *standard* providing a description and rationale for each.

- **Practice:** *Practices* are strategies that further describe program or staff performance. Such practices are derived from the *DBHIDS Practice Guidelines* and are scored by NIAC teams. Taken together the 13 *standards* are comprised of 53 *practices*.

- **Information Source(s):** Evidence used to score program performance. Information sources are outlined in ***Appendix D.***

1) Each NIC *practice* is scored on a four (4)-point scale, ranging from zero (0) to three (3).
   - **Zero** (0) indicates that the practice is *not present,* not occurring or in the case of documentation is *duplicated.*
   - **One** (1) indicates that the practice is *partially present or occurring intermittently.*
   - **Two** (2) indicates that the practice is *fully present and/or thoroughly executed.*
   - **Three** (3) indicates *excellence in addressing the recovery/resilience-oriented practice.*

2) Points earned on each *practice* are summed to create a *standard* score.
3) *Standard* scores are then sub-totaled to create a score for each *domain*, to include the section on the *Foundations of Excellence in Service Delivery*.
4) Each of the four practice *domain* scores plus the *Foundations of Excellence in Service Delivery* score is then weighted based on Table I (see below).
5) The five (5) weighted scores are summed to create a *Level of Care* score.  The *Level of Care* score determines the DBHIDS *Network Recognition Level* (Table II) for that level of care within the agency.

## TABLE I:  Weightings for Domains & Foundations of Excellence in Service Delivery

| Domains and Organizational Focus | Weighting |
|---|---|
| Foundations of Excellence in Service Delivery | 20% |
| Domain 1: Assertive Outreach and Initial Engagement | 15% |
| Domain 2: Screening, Assessment, Service Planning and Delivery | 30% |
| Domain 3: Continuing Support and Early Re-Intervention | 15% |
| Domain 4: Community Connection and Mobilization | 20% |
| Total Level of Care Score | 100% |
|  |  |

## Network Recognition Levels

Each level of care within an agency will receive one of four possible recognition levels based on their *Total LOC Score*. Each *Recognition Level* reflects the degree to which the agency's level of care meets the requirements of the *practices* and *standards* that comprise the *Foundations of Excellence in Service Delivery* and the four domains. The four recognition levels allow providers with a range of capabilities to successfully meet the requirements for network approval. The *Network Approval* level is required to participate in the DBHIDS network.

Each agency LOC score will be determined by the NIAC team through the use of a sampling process. The entire 53 practices noted within the NIC will not be collected at each program for each level of care; instead, a selection of NIAC on-site activities will be employed at different program locations to ascertain a LOC score. The four levels of recognition are as follows:

## Table II: Network Recognition Levels

| Recognition Level | Total Level of Care Score | Outcome/Next Site Visit | Associated Incentives/Restrictions |
|---|---|---|---|
| Network Status Denied/ Suspended | < 64% | Board Action required to determine next steps along with a concrete performance improvement plan (PIP) with NIAC oversight | *Inability to apply for RFPs/RFAs/RFIs; unqualified for enhanced rates; ineligible for pay for performance; closed to admissions* |
| Level 1: Network Provisional Status | 65- 74% | One year network provisional status along with PIP with mandatory technical assistance | *Inability to apply for RFPs/RFAs/RFIs; unqualified for enhanced rates; ineligible for pay for performance* |
| Level 2: Network Approval | 75-89% | Two year network approval status | *Ability to apply for RFPs, RFAs, RFIs; qualified for enhanced rates; eligible for pay for performance; eligible for training initiatives* |
| Level 3: Network Approval with Distinction | 90% | Three year network approval status | *Recommendation for Center of Excellence Status; ability to apply for RFPs, RFAs; RFIs; eligible for pay for performance; eligible for training initiatives; qualified for enhanced rates; increased referrals; status recognition publicized* |

# SECTION III:  THE NETWORK INCLUSION CRITERIA (NIC) with COMPREHENSIVE DETAIL of the STANDARDS and PRACTICES

Section III describes in detail each of the four NIC *Domains* including the *Foundations of Excellence in Service Delivery* section, identifying the associated *Standards,* the relevant *Objective* for each *Standard*, and the *Practices* applicable to that *Standard*.  The emphases found in both the meaning and language of each NIC Practice, builds upon the practices and strategies in the DBHIDS *Practice Guidelines for Recovery and Resilience-Oriented Treatment*.  The strategies and practices found in both the *Practice Guidelines* and the NIC are meant to "help providers implement services and supports that promote resilience, recovery and wellness, … they are not intended to encapsulate all possible services or supports …" It is assumed that providers may select similar or alternative practices either from the *Guidelines,* or be guided by evidence-based/informed/etc. practices or those that have demonstrated promise, to associate with the NIC standards.  However, the values, intent and spirit of the *Practice Guidelines* shall be evident in all adopted practices.

When installing particular practices within agencies the implementation may vary depending on the level of care (LOC) where the practice is being installed.  For instance "access" practices used in an Outpatient Program may differ from those used in a Community Integrated Recovery Center (CIRC).  Given the collaborative approach of a NIAC review, such differences in implementation will be understood.

The DBHIDS recommends that agencies establish an intentional change process to select, prepare staff and implement the use of *Practice Guideline* strategies.  The establishment of a *change management team or similar* is recommended.  Resources and toolkits of the Substance Abuse and Mental Health Services Administration (SAMHSA), the DBHIDS Evidence-Based Practice and Innovation Center (EPIC), the DBHIDS Tools for Transformation and other relevant Department, State and Federal assets can all contribute to the transformation of practice and sustaining innovation moving forward.

***Note:  The information contained in this document under no circumstances supersedes the Department of Public Welfare (DPW) regulations, Department of Health (DOH) regulations or existing Community Behavioral Health (CBH) Documents (e.g., Provider Manual, Utilization Management Guide). Therefore please continue to follow all regulations and guidelines.***

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**This first section of the DBHIDS Network Inclusion Criteria consists of the *Foundations of Excellence in Service Delivery*, followed by the four (4) Domains and their associated practices.**

# Foundations of Excellence in Service Delivery

*Foundations of Excellence in Service Delivery*
*Standard A:  Creating Excellence in Agency Staffing and Development*

*Objective:  Leadership and professional development are vital to assuring continuous growth, innovation and opportunity within agencies.  The adopted practices of an agency drive staff composition, competencies and the roles necessary to support the recovery/resilience journeys of people.  An agency annual staff training and development plan is in place and includes individualized learning plans for staff.  The individualized plan reflects the staff person's development, along with the skills required for the position.  Educational opportunities are made available both onsite and in the community.*

*\*Please note that the staffing requirements indicated in the current CBH Credentialing Manual will remain in place until further notice.*

**Practice 1.**  Agency staffing reflects the culture and demographics of the community being served. Bilingual staff is available and/or the agency provides interpreter services. A blend of professional, peer and volunteers are staffed across the agency.  *(Information Sources: Peer Culture Survey, Observations, Staff Roster)*

**Practice 2.**  An annual staff training and development plan is in place for the agency and includes a calendar of annual trainings; additionally, individualized learning plans are in place for staff.  The agency maintains full documentation of all training curricula (including handouts, slides, etc.) and training event attendance.  *Please refer to **Appendix H** for the scoring of training implementation.  (Information Sources:  Staff Files, Training Materials)*

**Practice 3.**  All clinical staff members are trained in trauma-informed assessment and interventions, and are able to therapeutically address the central importance of generational, lived and current traumatic experience.  *(Information Sources:  Training Materials)*

**Practice 4.**  People receiving services and their families of choice are invited to agency-sponsored training events.  Information is provided about community-based training opportunities valuable to their recovery/resilience journey.  The agency affords opportunities for individuals to speak about their successes and challenges within the context of agency-sponsored training and events.
*(Information Sources:  Living Reviews, Peer Discussion Groups)*

**Practice 5.**  Supervisory staff receive specialized training in the empirically-informed approaches adopted by the agency in order to guide their implementation.  *(Information Sources:  Staff Files, Training Materials)*

**Practice 6.**  Strategies and implementation processes are in place to inform all staff regarding current information on behavioral, physical and community health related research and innovative practices.
*(Information Sources: Training Materials)*

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*Foundations of Excellence in Service Delivery*
*Standard B:  Conducting Supervision in a Recovery/Resilience-Oriented Environment*

*Objective: A vigorous approach to recovery/resilience-oriented clinical supervision by qualified staff is in place and ensures:  excellence in the delivery of services; the ongoing development of staff; alignment with, adoption of and continued implementation of the DBHIDS Practice Guidelines; and*

*implementation of agency-selected empirically-informed approaches. Additionally, administrative practices are in place to assure compliance with DBHIDS, state and federal regulations as well as agency policies and procedures.*

**Practice 1.** All clinical staff receive recovery/resilience-oriented clinical supervision. Supervision is focused on improving outcomes for people receiving services, as well as addressing staff strengths and challenges. Supervision sessions support the individualized learning plan for each staff member. *Please refer to **Appendix I** for the scoring of recovery/resilience-oriented supervision. (Information Sources: Supervision Notes/Logs, Written Policy)*

**Practice 2.** Supervisors provide ongoing coaching and strength-based support to peer staff; this is maintained through ongoing supervision and evaluation. *(Information Sources: Supervision Notes)*

**Practice 3.** Performance evaluations occur for all staff. After the staff person's probationary period ends, performance evaluations are conducted on an annual basis, at a minimum. Areas for staff improvement are identified as part of the performance evaluation and are linked to the individual's ongoing learning plan. *(Information Sources: Staff Files – review performance evaluations, Written Policy)*

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## Foundations of Excellence in Service Delivery
## Standard C: Determining Quality of Care and Outcomes

*Objective: Agency strategic planning processes are in place including the use of continuous quality improvement in determining refinements, new services and course corrections for the organization and its services.*

**Practice 1.** The creation and use of agency tracking systems at all levels of care is used to provide data to support continuous improvement in the quality of services. Please see **Appendix G-V** for measures for suggestions. *(Information Sources: Tracking System)*

**Practice 2.** Feedback from participants (to include children, youth and adults), families, allies and program alumni is obtained (both quantitative and qualitative feedback). The findings from the data collection and feedback from a sampling of participants, families, allies and program alumni are analyzed on a *quarterly* basis. The analysis informs the selection and implementation of program refinements based on program and participant needs, and includes feedback from the reports of the Consumer Satisfaction Team (CST) when available. *(Information Sources: Parent Surveys, Peer Culture Survey, Written Policy)*

**Practice 3.** Agencies measure the effectiveness of the services provided. Evidence of emerging disparities concerning access, engagement, service quality, and outcomes are routinely monitored. Surveys or other measures are used for tracking and reporting purposes. *(Information Sources: Staff Reports, Tracking System, Written Policy)*

**Practice 4.** The role and impact of peer support are continuously evaluated to determine its contribution to the culture of the program. The peer support staff, volunteers and people receiving services are involved in this ongoing task. *(Information Sources: Peer Discussion Group, Staff Reports, Written Policy)*

*This concludes the section on agency-level practices, entitled the Foundations of Excellence in Service Delivery. The next section of the NIC addresses the four Domains.*

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## Domain 1:    Assertive Outreach and Initial Engagement >
## *Standard A:  Promoting Easy Access and Responsive Engagement*

*Objective:  The delivery of timely, efficient and responsive services are in place for children, youth and adults who are in need of or seeking behavioral health services and/or supports.  Access includes a robust partnership with the community including but not limited to the following: increasing their awareness of the scope of services available; active public relations efforts; positive working alliance with other local provider agencies, etc.  Additionally, a variety of engagement practices are used to enhance the services offered to individuals and families. Engagement is characterized by the establishment of genuine, mutually respectful and trusting relationships.*

**Practice 1.**  Appointments are timely and the agency's hours-of-operation are flexible. Courtesy calls are made to remind people of appointments and follow up calls are made regarding missed appointments. Peer support should be encouraged to increase the success of the engaging individuals in services. *(Information Sources: Agency Manual, Clinical Records, Peer Discussion Groups)*

**Practice 2.**  Physical plant accommodations are made to ensure that the needs of the individuals are met. These may include ramps, wide doorways, etc.  It is the agency's responsibility to make a referral if this level of need cannot be accommodated. *(Information Sources: Observations)*

**Practice 3.** The program assists individuals and families in pursuing and obtaining skills and resources to allow for independent transportation to and from the service location(s).  Transportation resources are discussed, needs are identified and supports are offered for individuals and family members.  *Additionally, information and assistance regarding access to childcare services is offered as needed.  (Information Sources: Peer Discussion Groups, Self-Appraisal)*

**Practice 4.**  People are acknowledged kindly upon entry into the program.  Phones are answered in a respectful and engaging manner. The program environment is welcoming and culturally appropriate (e.g., with reading materials, pictures, etc. that reflects the cultural array of individuals served).  *The waiting area for programs that provide services to children should include age-appropriate items (e.g., toys, books, etc).  (Information Sources: Observations, Living Review)*

**Practice 5.**  Agencies are creative in using technology to engage individuals, families and community partners (e.g., text messages, emails).  These outreach efforts and communications are documented. Agencies assist individuals and families in accessing technology resources in the community; these resources may be available at the agency, in the library, places of worship or other community centers. *(Information source: Clinical Records, Living Reviews)*

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## Domain 1:    Assertive Outreach and Initial Engagement
## *Standard B:  Facilitating Early Intervention*

*Objective:  Agencies are proactive in identifying and addressing behavioral health challenges through assertive outreach, peer engagement, community partnerships, as well as community education and public awareness campaigns.*

**Practice 1.**  Partnerships and learning exchanges are established with Child Protective Services, community police, fire, paramedics, and other emergency service responders to provide education and cross-system collaboration.  *(Information Sources: Executive Level Interview, Self-Appraisal)*

**Practice 2.**  The agency emphasizes the prevention and early identification of behavioral health issues. Collaboration with community partners (e.g., recreation centers, child welfare, schools, juvenile justice

organizations, etc.) is established with the aim of identifying children, youth and adults who may benefit from behavioral health supports. *(Information Sources: Executive Level Interview, Self-Appraisal)*

**Practice 3.** Efforts are made to educate the community regarding behavioral health issues and resources. The agency uses assertive outreach strategies to identify and address the unmet behavioral healthcare needs of those in the community (e.g., public awareness campaigns, community meetings, advertisements, flyers, word of mouth, mobile teams, etc.). *This includes outreach to school staff in the Philadelphia School system.* *(Information Sources: Executive Level Interview, Self-Appraisal)*

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## Domain 2: Screening, Assessment, Service Planning and Delivery
### Standard A: Assuring Responsive Triage/Prescreening (Urgent Screening)

*Objective: Agencies are equipped to conduct the full range of behavioral health triage/prescreening and urgent screening services to the community. Screening methods are based on a holistic and comprehensive approach of potential challenges facing individuals seeking services. Agencies proactively screen/assess for individuals in urgent situations and provide the necessary supports to assure the safety of the individual and family members.*

**Practice 1.** High risk behavioral assessments are completed, including the screening for suicidality and homicidality; bio-medical/physical concerns may require a medical evaluation and assessment of withdrawal-symptom severity. Screening for suicidality should include the history of prior attempts, assessment of potential lethality of these attempts, needed medical interventions as a result of the attempts, confirmation of self-reports from ancillary sources, current plan, means to carry out the plan and potential lethality of the current plan. Clinicians should be aware of triggers, including anniversaries and holidays. Agencies should have measures in place, to include possible referrals for an emergent evaluation for positive high risk screens. Incident reporting occurs at the state and City/CBH level if a suicidal/homicidal attempt is made. *(Information Sources: Clinical Records, Written Policy)*

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## Domain 2: Screening, Assessment, Service Planning and Delivery
### Standard B: Conducting Strength-Based Assessments and Evaluations

*Objective: Person-first assessments and evaluations are a strength-based process that fully embraces the principles of recovery/resilience, cultural appropriateness and relevance. A strength-based assessment requires a trusting relationship with the person and is ongoing. Therefore the individual is continually assessed to reflect the ongoing identification of the person's strengths and achievements in the recovery/resilience process. Trauma assessment and treatment and/or referral to trauma-informed services for children, youth, adults, older adults and families/allies are essential during the assessment process, at the beginning of engagement and throughout the service experience.*

**Practice 1.** Critical information is collected within the assessment and evaluation process and shall include all items indicated in *Appendix G-I. (Information Sources: Clinical Records)*

**Practice 2**. Trauma-relevant assessments/tools are administered. All children, regardless of age, are screened for evidence of bullying and abuse (physical, verbal, cyber, etc.). Examples of tools/instruments are the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2), Post Traumatic Stress Disorder Reaction Index (PTSD-RI), and Traumatic Events Screening Inventory (TESI). *Trauma-assessment tools for children should also include drawings, play materials, etc. (Information Sources: Clinical Records)*

**Practice 3.** Upon completion of the evaluation a formulation is co-created with the individual. The individual's and family's personal strengths and community supports are vital to consider in its creation. Additionally, the formulation corresponds to an accurate DSM diagnosis, describes the precipitating, perpetuating, predisposing and protective factors, and informs the next steps in the recovery/resilience planning process. *(Information Source:  Clinical Records)*

**Practice 4**. Empirically supported screening and strength-based assessment tools have been selected and implemented based on the needs and challenges of the individuals seeking services. *(Information Sources: Clinical Records)*

**Practice 5.** For youth/adults seeking addiction services, the American Society of Addiction Medicine Criteria (ASAM PPC–2R) or the Pennsylvania Client Placement Criteria (PCPC) is used in conjunction with a structured interview to determine the appropriate services. A mechanism must be in place for making referrals when a PCPC or ASAM reveals that an agency is unable to accommodate the individual and family. *(Information Sources:  Clinical Records - PCPC /ASAM document)*

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# Domain 2:    Screening, Assessment, Service Planning and Delivery
## *Standard C:  Advancing Excellence in Resilience/Recovery Planning and the Delivery of Services*

*Objective:  Recovery/resilience planning includes collaboration among individuals, families/allies, provider agencies and other relevant stakeholders.  Collaborative service teams are created among agency staff (including all specialties) and relevant community partners, meaningful to the person. Delivery of services is person-directed, individualized, age-appropriate, culturally sensitive and strength-based.  Recovery/resilience planning is aspirational, emphasizing the attainment of the knowledge and skills necessary to achieve a fulfilling life in the community.  The identification of personal goals, short-term achievable steps and ongoing evaluation of progress are fundamental to planning in a recovery/resilience approach to care.*

**Practice 1.** Individuals, their families/allies and other supporters take the lead and are supported in the key decision–making processes relevant to their services.  Recovery/resilience plans are established and driven by the individual/family receiving services.  A trauma-informed approach to care is implemented that: assures that the trauma history is explored; recognizes the presence of trauma symptoms; and acknowledges the role that trauma has played and/or continues to play in their lives. *(Information Sources: Clinical Records, Living Reviews)*

**Practice 2.** Recovery/resilience plans are written in a strength-based manner and are informed by the person's unique culture (including faith, spirituality, sexual orientation, etc)**.** Individual and family strengths change, grow and evolve over time, and as such their ongoing identification and use in recovery/resilience planning is evident. *(Information Sources:  Clinical Records)*

**Practice 3.** Recovery/resilience plans are 'living' documents that serve as a blueprint toward achievement and are consistently utilized throughout service delivery.  The review and updating of plans occurs as goals are achieved or as priorities shift; these plans are not merely reviewed at specified intervals or driven by the expectations of regulation or policy. *(Information Sources:  Clinical Records, Living Reviews)*

**Practice 4.** Recovery/resilience goals, objectives and steps are measurable, achievable, and developmentally appropriate, and address all aspects of the person's life.  Recovery/resilience plans shall include DSM diagnoses, the methods of service delivery (e.g., individual therapy) and all corresponding dates. Updated plans include the documentation of progress. *(Information Sources:  Clinical Records)*

**Practice 5.** Progress notes capture the essence and outcome of session activities. See ***Appendix G- II*** for details. The progress notes shall link with the goals and objectives reflected in the individual's recovery/resilience plans and assessments/evaluations. *(Information Sources:  Clinical Records, Living Reviews)*

**Practice 6.**  A safety plan is in place for all children, youth, adults and families at risk for ongoing traumatization.  A safe environment is purposely and persistently maintained to serve the needs of those receiving trauma-oriented services.  *(Information Sources:  Clinical Records)*

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## Domain 2:    Screening, Assessment, Service Planning and Delivery
### *Standard D:  Ensuring Safe and Effective Medication Practices*

***Objective:  The agency documents an individual's use of medication, psychotropic, herbal and home remedies, and the therapeutic impact of the medication, as well as the individual's experience of any side effects.  Given the collaboration among the individual receiving services, family members and all team members, knowledge of progress in addressing the person's medical challenges is critical to the ongoing success of their recovery/resilience plan.  Medical education must be provided and individuals must be screened and treated for Metabolic Syndrome.***

**Practice 1.**  Documentation of medication monitoring shall include all items indicated in ***Appendix G-III***. *(Information Sources:  Clinical Records)*

**Practice 2.**  Comprehensive medication histories and current medications are documented and updated routinely, including the use of non-psychotropic, as needed (*PRN)*, and over-the-counter (OTC) medications.  Chronic conditions are highlighted (i.e. Diabetes, HIV, etc.).  *(Information Sources:  Clinical Records)*

**Practice 3.**  Allergies involving medication are noted in detail.  *(Information Sources:  Clinical Records)*

**Practice 4.**  Ongoing monitoring is required to assure that individuals are benefiting from the medication prescribed.  Documentation in this regard is evident (e.g. areas of progress, continuing or new challenges for the person, collaboration with the therapist/team, detailed rationale of medication changes, and possible referrals).  *(Information Sources:  Clinical Records, Living Reviews)*

**Practice 5.**  Outreach for missed medical appointments must occur and be documented.   *(Information Sources:  Clinical Records, Living Reviews)*

**Practice 6.**  There is compliance with CBH Bulletin (#10-33) regarding informed consent, use of off-label medications, and the use of educational materials for parents about the risks and benefits of all of the major medications.  Please note that family of choice cannot be in lieu of the individual's presence in the medication management/monitoring session. *(Information Sources:  Clinical Records, Parent Surveys, Written Policy)*

**Practice 7.**  There is compliance with Provider Bulletin (#07-07) regarding the Screening for and Treatment of the Components of Metabolic Syndrome.  Each provider must adopt policies and procedures to address the screening and monitoring of Metabolic Syndrome.  This policy must address all required elements and medication management progress notes must reflect the practice of this policy. *(Information Sources:  Clinical Records, Written Policy)*

**Practice 8.** Methadone treatment centers are expected to provide, or be able to refer to, a full range of services including vocational, educational, legal and health. Treatment centers will comply with all state

and federal licensing regulations. Agencies offer an integrated and holistic treatment approach that provides psychosocial treatment, in addition to the provision of methadone, and that adequately screens for and treats co-occurring psychiatric conditions.  Site visits may include evaluation of adherence to counseling requirements, issues around potential drug misuse, urine drug screening and follow up. *(Information Sources:  Clinical Records, Written Policy)*

## Domain 3:    Continuing Support and Early Re-Intervention
### *Standard A:  Embracing Comprehensive Continuing Support*

*Objective:  People receiving services shall be given the support necessary to establish meaningful connections and belonging to their chosen communities.  In anticipation of program completion (graduation, commencement, etc.), people receiving services, with the help of staff, finalize continuing support plans.  The development of these plans begins during the early phases of care to facilitate the growth of relationships (family, peers, key supporters, etc.) and community connections beyond the treatment experience.*

**Practice 1.**  There is evidence of continuing support planning beginning at intake and continuing throughout the service experience at the program.  There is an expedited re-entry process to meet the needs of the individual. *(Information Sources: Clinical Records, Living Reviews)*

**Practice 2.**  Documentation of continuing support planning shall include all items indicated in ***Appendix G-IV.*** *(Information Sources:  Clinical Records, Living Reviews)*

**Practice 3.**   Staff and peers partner with individuals to assist them in connecting and engaging with resources.  These may include but are not limited to the National Alliance on Mental Illness (NAMI), Family Resource Network (FRN), Alcoholics Anonymous, ProAct, Parents, Families & Friends of Lesbians and Gays (PFLAG), therapeutic preschool or afterschool programs and other mutual self-help fellowships. *Additionally, there is an expedited re-entry process to the person's previous level of care, or entry into a new level of care, based on the individual's needs. (Information Sources:  Clinical Records, Peer Discussion Groups, Staff Focus Groups)*

## Domain 4:    Community Connection and Mobilization
### *Standard A:  Energizing Children, Youth and Adult Peer Culture, Support and Leadership*

*Objective:  Individuals, families (both biological and of choice) and the community drive the development of a vibrant peer culture where the needs of individuals and the strategies important to growth are identified, promoted and initiated.  The inclusion of social support and family connection is emphasized.*

**Practice 1.**  The program actively encourages, develops and recruits peer leaders (to include children, youth and adults) by identifying the skills and capabilities of peers from within the program.  Peers, families and youth are involved in making programmatic decisions. *(Information Sources: Peer Discussion Groups, Peer Culture Survey, Staff Focus Groups)*

**Practice 2.**  The program demonstrates the development of family-to-family peer support through planned activities (open houses, meetings with families of choice, behavioral health education, support groups, use of the Family Resource Network, etc). Family members and families of choice are engaged in program development activities.  *(Information Sources:  Peer Culture Survey, Self-Appraisal, Staff Focus Groups)*

**Practice 3.** Peer leadership and support opportunities (e.g., peer-led groups) are facilitated by individuals receiving services, to include children, youth and adults. Individuals interested in facilitating groups receive coaching and support on an ongoing basis from other peers and the staff. The agency provides opportunities for youth to demonstrate leadership skills in peer group settings. *(Information Sources:  Parent Surveys, Peer Culture Survey, Peer Discussion Groups)*

**Practice 4.** There is evidence that the program encourages and fosters the use of natural supports (e.g., family, friends, significant others, neighbors, community, etc). *(Information Sources: Living Reviews, Staff Focus Groups)*

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# Domain 4:    Community Connection and Mobilization
## *Standard B:  Strengthening Community Inclusion and Mobilization*

*Objective:  Agencies acknowledge and make full use of the community's <u>role</u> AND <u>potential</u> in providing rich opportunities to advance the recovery of individuals.  It is recognized that there is a critical need for vibrant, reciprocal community partnerships in supporting the recovery and resilience of the individual.*

**Practice 1.**  Agencies adopt practices, based on the preferences, cultures and needs of individuals receiving services that foster inclusion into the community. An example of a practice may be that staff accompany a person to a community event in support of their recovery/resilience plan and to generalize learned skills. Additionally, the program connects individuals with employment, education and volunteer opportunities in the community. *(Information Sources: Peer Discussion Groups, Self-Appraisal, Staff Focus Groups)*

**Practice 2.**  Providers have established formal and informal reciprocal agreements with a variety of community partners to serve the continuing care and needs of people receiving services.  Relationships are created with the Department of Human Services (DHS), the Office of Supportive Housing programs, Family Court, school districts, places of worship and other community organizations (e.g., faith-based groups, food shelters, housing, educational resources) in support of this effort.  There is evidence of a Memorandum of Understanding between key partners and ongoing collaboration between the provider agency and relevant community organizations. *(Information Sources:  Executive Level Interview, Self-Appraisal)*

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# Domain 4:    Community Connection and Mobilization
## *Standard C:  Integrating Physical and Behavioral Health Services*

*Objective:  Seamless relationships are created between the treatment system and the broader community by way of bi-directional referrals and collaborations.  Collaborative partnerships are established with local physical health providers to promote the physical and behavioral health and wellness of people who access these resources.*

**Practice 1.** Relationships and bi-directional referral agreements are established with physical health providers (to include pediatricians).  Obstacles to collaboration are addressed.  For example, if behavioral health issues are identified resulting from medical appointments, physical health providers will consult with the behavioral health agency and vice versa. *(Information Sources:  Clinical Records, Self-Appraisal)*

**Practice 2.**   Providers assist participants in accessing critical preventative and diagnostic healthcare services through referrals or coordination with community healthcare supports.  Such prevention, screening and diagnostic supports include but are not limited to the following: Tuberculosis (TB) testing,

blood pressure screening, etc.; Sexually Transmitted Diseases (STD) testing (to include HIV/AIDS); pre-natal care, reproductive health, child well-visits and immunizations; and, annual physical exams, dental checkups and other routine medical screening. *(Information Sources:  Clinical Records, Living Reviews, Written Policy)*

**Practice 3.** The agency has reached out to primary care physicians (PCPs) to offer education to these providers regarding behavioral health diagnoses, treatment, empirically-informed approaches, trauma-informed care and the integration of care.  PCPs educate the behavioral health community on a variety of physical healthcare challenges including current community illness trends, chronic diseases and other medical complications/presentations that will prove helpful to staff and individuals. *(Information Sources: Training Materials)*

# SECTION IV:  APPENDIX

# Appendix A: References

*The References section identifies a sampling of Department and SAMHSA monographs, manuals or papers to assist providers in the development of their programs, practices, staff, people receiving services and the community.  Also refer to the references section of the Practice Guidelines.*

**1.  Practice Guidelines for Recovery and Resilience-Oriented Treatment** *> http://www.dbhids.org/assets/Forms--Documents/transformation/PracticeGuidelines.pdf*

**2.  An Integrated Model of Recovery Oriented Healthcare** *> http://www.dbhids.org/assets/FormsDocuments/4.2.1.5IntegratedModelofRecoveryOriented.pdf*

**3.  Recovery Management and Recovery Oriented Systems of Care** *>http://www.dbhids.org/assets/Forms--Documents/transformation/BillWhite/2008RecoveryManagementMonograph.pdf*

**4.  Tools for Transformation:  Peer Culture/Support/Leadership** *> http://www.dbhids.org/assets/Forms--Documents/4.2.1.3-PDF-8.pdf*

**5.  Tools for Transformation:  Community Integration** *> http://www.dbhids.org/assets/Forms--Documents/4.2.1.3-PDF-9.pdf*

**6.  Tools for Transformation:  Extended Recovery Supports** *> http://www.dbhids.org/assets/Forms--Documents/4.2.1.3-PDF-10.pdf*

**7.  Tools for Transformation:  Person First Assessment - Person Directed Planning** *> http://www.dbhids.org/assets/Forms--Documents/personFirst.pdf*

**8.  Tools for Transformation:  Holistic Care** *> http://www.dbhids.org/assets/Forms--Documents/holistic.pdf*

**9.  Approaches to Recovery Oriented Systems of Care at the State and Local Levels:  Three Case Studies** *> http://www.dbhids.org/assets/Forms--Documents/transformation/CSATStateandLocalLevelsROSC2009.pdf*

**10.  SAMHSA Evidence-Based Practices Kits** *> http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs*

**11.  SAMHSA-HRSA Center for Integrated Health Solutions** *> http://www.integration.samhsa.gov/*

**12**.  White, W., Schwartz, J. & the Philadelphia Clinical Supervision Workgroup (2007). *The Role of Clinical Supervision in Recovery-oriented Systems of Behavioral Healthcare.* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

**13. Policy Regarding the Screening for and Treatment of the Components of Metabolic Syndrome Bulletin # 07-07 >** *http://www.dbhids.org/assets/Forms--Documents/Bulletin0707.11.01.2007.pdf*

**14. Provider Bulletin # 10-03 -Use of Psychotropic Medications in Children and Adolescents (FDA Approved and Off-Label) >** *http://www.dbhids.org/assets/Forms--Documents/CBH/Bulletin-10-03-Revised2.pdf*

**15.  Provider Bulletin # 07-3 Philadelphia Department of Behavioral Health Significant Incident Reporting, September 1, 2007 >** *http://www.dbhids.org/assets/Forms--Documents/Bulletin052.pdf*

# Appendix B:  Glossary of Terminology and Language

## Glossary of Language

| Traditional Phrases | Replacement Terms |
|---|---|
| Addict | In recovery from alcohol or other drug use |
| Clients/ Members | Individuals/People receiving services |
| Comorbidity | The need for integrated care |
| Culturally Competent | Person-First |
| Decompensating | Having a difficult time/is experiencing... |
| Difficult | Challenging |
| Disabled | A person living with a disability |
| Discharge Plans | Continuing Support Plans |
| Drug and Alcohol | Substance Use or Alcohol and Other Drugs |
| Graduation | Transition |
| High functioning | Is really good at... |
| Low functioning | Challenges caring for self |
| Non-compliant | Choosing not to; making other choices |
| Overcome Adversity | Resilience |
| Problem | Challenge |
| Relapse Prevention | Recovery Management |
| Relapse | Intermittent Success/ Resumed use |
| Resistant to Treatment | Not ready to engage |
| Substance Abuse | Substance use |
| Suffering From | Working to recover from |
| Treatment Plans (Adults) | Recovery Plans |
| Treatment Team | Recovery support team |
| Treatment Plans (Children) | Goal Plans/Service Plans/Resilience Plans/Plan of Care |
| Unmotivated | Uninspired |
| User of the System | Resourceful - self advocate |

# Appendix B, continued:  Glossary of Terminology

**In addition to the listings below, please go to following address for an
extensive behavioral healthcare glossary of terms >
*http://www.dbhids.org/assets/Forms--Documents/Glossary.pdf***

*Accountability Partnership* - Describes the relationship between the DBHIDS and an agency as having different but complimentary roles in achieving service excellence and the outcomes desired by people receiving services.

*Bi-Directional Referrals and Collaborations* – Refers to the integration of physical and behavioral health care, whereby physical health providers refer individuals to and collaborate with behavioral health providers  when the individual presents with behavioral health concerns; likewise behavioral health providers refer individuals to and collaborate with physical health providers when the individual presents with medical concerns.

*Change Management Team* - Refers to a DBHIDS recommendation that agencies create an internal workgroup to plan and execute the implementation of the Practice Guidelines and Evidence-Based/Supported/Informed/Suggested Practices.

*Community* - Refers to places where people live, work or connect (neighborhoods, jobs, community centers etc.), gatherings that may support a person's interests (reading circles, clubs, etc.), assemblies where citizens meet for a purpose (political parties, civic organizations, etc.), and community organizations and resource connections that support a person's ambitions (schools, jobs, libraries, practical resources, etc.). Creating relationships and opportunities within all of these "communities" helps a program and its services advance the recovery of those they serve.

*Community Connection and Belonging*  - Belonging and community connection are the recovery-oriented social foundations and critical success factors to meaningful and individualized community living.  This can be viewed as a combination of: family, kinship and other natural support networks; the accessibility and variety off peer support; traditional and contemporary cultural elements that add to participants' and families' strength, resilience and recovery capital; and the participation in meaningful community activity that may include employment, volunteerism, participating in community watch efforts or other community-oriented activities.

*Continuous Quality Improvement (CQI)* - An agency-driven process that seeks to improve the provision of services with an emphasis on future outcomes.  CQI uses a set of tools to understand and identify program challenges or barriers to success, with an emphasis on maintaining quality in the future, not just controlling a process.

*Cross-System Collaboration* - Augments the agency's multi-disciplinary team by developing partnerships with behavioral health and non-behavioral health agencies (criminal justice, educational institutions, etc.).

*Evidence-Based Practice(s)* - Interventions, which have a body of controlled studies, and where at least one meta-analysis shows strong support for the practice.  Results have a high level of confidence due to the randomized control methodology.

*Evidence-Supported Practice(s)* - Interventions that have demonstrated effectiveness through quasi-experimental studies; data from administrative databases or quality improvement programs that shed light on the impact of the program or intervention; interventions that may have a single controlled study that shows effectiveness, but the results haven't been replicated or demonstrated with the populations of interest; program evaluations that provide strong evidence of the effectiveness of an intervention or

clinical approach (e.g., cohort management strategies).

**Evidence-Informed Practice(s)** - Evidence of the effectiveness of an intervention is inferred based on a limited amount of supporting data; based on data derived from the replication of an EBP that has been modified or adapted to meet the needs of a specific population; this data is fed back into the system. New interventions are developed, traditional interventions are modified, and ineffective interventions are eliminated; provides a template/framework for other systems to modify their programs and interventions.

**Evidence-Suggested Practice(s)** - Consensus driven, or based on agreement among experts; based on values or a philosophical framework derived from experience, but may not yet have a strong basis of support in research meeting standards for scientific rigor; provides a context for understanding the process by which outcomes occur; based on qualitative data, e.g., ethnographic observations.

**Family and Significant People** - Agencies broadly define and encourage accessing a network of support that is currently or could be available to the individual in support of their recovery journey. This network of family and significant people could include: blood relatives; friends and associates; healers and spiritual mentors; employers, valuable community members meaningful to the individual, etc.

**Family-to-Family Peer Support** - Agencies encourage, at times develop and at others times access family resources (Family Resource Network) all designed to provide family support to other families (both one-to-one, family groups and other arrangements) mutual support as they are involved in the recovery of a family member or need support and strategies in addressing behavioral health issues in their own family.

**Holistic Care** - Agencies create a menu of supports and general wellness approaches to health including: ongoing monitoring and maintenance of physical health; support in living a meaningful life in the community; training in self-management strategies; daily wellness approaches for coping with symptoms such as WRAP (Wellness Recovery Action Planning), etc. During initial and ongoing assessment people are educated and are encouraged to take advantage of the benefits to a holistic approach to care.

**Individualized Learning Plans** - A document of the training and professional development needs of an individual staff person. Typically refers to areas of conceptual understanding and application needed to improve a staff person's performance.

**Living Documents** - Recovery and resilience oriented assessment, planning and service delivery are dynamic processes subject to change as preferences, new goals and new understandings emerge in the person as their recovery / resilience journey progresses.

**Natural Supports** - Personal, family, social and community resources available to a person in their recovery/ resilience journey. Such personal resources include the individual's strengths, talents, abilities and experiences. Recovery/resilience oriented services work with family members and allies to create natural environments that promote recovery and resilience and assist people in making clear and direct requests of their natural support system, so that they play an active role in creating positive environments for themselves.

**Peer Culture, Support and Leadership** - This is one of the four pillars of the DBHIDS System Transformation and as such can be more fully understood conceptually by reviewing the Practice Guidelines and in practice by discussing these issues with a Certified Peer Specialist. The infusion of activities to encourage peer leadership and support assists agencies in shifting the emphasis and culture of care to a recovery/resilience orientation.

**Peer-Led Groups** - Agencies create opportunities for people receiving services and alumni to conduct peer-led support groups both on site and in the community. Where appropriate and feasible, agencies create culture-specific (e.g., age, gender, language, ethnicity) groups. Peer groups may also address the needs of

children of troubled families in which substance use, mental illness or other challenges are present. A role for an agency peer government can be to assist in identifying and guiding the implementation of peer-led groups.

***Person-First Assessments and Evaluations*** - An approach to assessment and evaluation that attends to the person's preferences, spirituality, gender identify, culture including ethnicity, gender, age, sexual orientation, religion, etc. Staff are trained to create a comfortable rapport and to conduct ongoing, comprehensive, strength-based, developmentally appropriate, trauma-informed and person-first assessments that take into account the individual's life context and ongoing goals and aspirations, as well as his or her presenting problems.

***Reciprocal Community Partnerships*** - Transformed systems both acknowledge and make full use of the community's role as the individual's and the family's home, and potential as a place of both challenge and healing. In transformed agencies, leadership recognizes the critical need for vibrant, reciprocal community partnerships in supporting the recovery and resilience of the individual—and of the entire community.

***Recovery*** - Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but also continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members. (Recovery Advisory Committee, City of Philadelphia DBH/MRS (*now called DBHIDS*))

***Recovery Capitol*** - Recovery capital is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery. (Granfield & Cloud, 1999).

***Recovery/Resilience Planning*** - A plan completed by the person in partnership with family members, significant people in the person's life and their treatment/recovery/resilience team. The person's plan is self-directed, hopeful, includes goals and achievable steps. The plan is dynamic reflecting the developmental nature of a recovery/resilience-orientation to services.

***Resilience*** - Resilience is a protective process that enables us to cope effectively when we are faced with significant adversities. It is a dynamic process that can change across time, developmental stage and life domain. All children, youth, adults, families and communities have the capacity to demonstrate resilience. There are many factors that enhance a child's resilience pathway including: positive relationships with caregivers, peers or a caring adult; internal strengths such as problem-solving skills, determination and hope; and environmental factors like effective schools and communities**.**

***Safety Plan*** - Agencies create a plan with people who have in the past or who are currently experiencing trauma, violence or danger either self-imposed or threatened externally. Staff uses non-shaming ways of recognizing and eliciting information about ongoing unsafe conditions (e.g., family violence) and offering support and resources in safety planning. Agencies assess current safely levels (e.g., at home, at school, in the community), and offer support and resources in safety planning.

***Staff Training and Development Plan (Agency)*** - Based on an assessment of individual staff training needs, anticipated national and/or local trends and findings from internal CQI efforts, agencies create an overall plan to address program and staff challenges that are informed by a focus on the desired outcomes of people receiving services and the development of the internal capacity to fulfill these needs.

***Supervision in a Recovery/Resilience-Informed Environment (Clinical Supervision)*** - Supervision driven by recovery/resilience principles that coaches individual staff in the use of these principles in order to achieve the desired outcomes of people receiving services. This partnership between supervisor and staff

person together identifies the strengths of the staff person, creates a learning plan to address performance challenges and actively attends to their relationship as an ongoing context for learning.

***Trauma-Informed Assessment and Interventions*** - Agencies possess the capability to both assess and treat people who have faced generational, lived and/or current traumatic experience.  Assessment includes methods to determine the complexity, chronicity and degree of impact on the individual and the family.  The assessment process is respectful and patient, using cues from the individual in determining the pacing of the interview.  Conceptual clarity and clinical supervision are paramount in the treatment of trauma.

# Appendix C: Acronyms

| | |
|---|---|
| **AA** | Alcoholics Anonymous |
| **AAS** | Access to Alternative Services (see CSN – Community Support Network) |
| **ACT NOW** | Advocacy & Training for New Opportunities to Work |
| **ADA** | Americans with Disabilities Act |
| **ADAPT** | Admission, Discharge and Planning Team |
| **ADHD** | Attention Deficit Hyperactivity Disorder |
| **ADL** | Adult Daily Living Skills |
| **AIC** | Achieving Independence Center |
| **AOD** | Alcohol and Other Drugs |
| **AS** | Adult Services |
| **ASAM** | American Society of Addiction Medicine |
| **ATR** | Access to Recovery |
| **BH** | Behavioral Health |
| **BHS** | Behavioral Health System |
| **BHRS** | Behavioral Health Rehabilitation Services |
| **BHSI** | Behavioral Health Special Initiatives |
| **BHTEN** | Behavioral Health Training & Education Network |
| **BCM** | Blended Case management |
| **BSC** | Behavioral Specialist Consultant |
| **BSR** | Behavioral Shaping Residence |
| **CA** | Cocaine Anonymous |
| **CAC** | Certified Addictions Counselor |
| **COD** | Co-occurring Disorders |
| **CANS** | Child Adolescent Needs and Strengths |
| **CANS-JJ** | Child Adolescent Needs and Strengths- Juvenile justice |
| **CASSP** | Children & Adolescent Services Systems Program |
| **CBH** | Community Behavioral Health |
| **CCM** | Clinical Care Management |
| **CDBG** | Community Development Block Grant |
| **CIRC** | Community Integrated Recovery Center |
| **CLA** | Community Living Arrangement |
| **CMRR** | Case Management Resource Report |
| **CPS** | Certified Peer Specialist |
| **CRC** | Crisis Response Center |
| **CRR** | Community Residential Rehabilitation |
| **CSN** | Community Support Network (formerly AAS) |
| **CST** | Consumer Satisfaction Team, Inc. |
| **CY** | Calendar Year (1/1/XX – 12/31/XX) |
| **CYS** | Children and Youth Services |
| **D&A** | Drug and Alcohol |
| **DBHIDS** | Department of Behavioral Health and Intellectual disAbility Services |
| **DBHHI** | Department of Behavioral Health Housing Initiative |
| **DD** | Dual Diagnosis |
| **DDAP** | Department of Drug and Alcohol Programs |
| **DHS** | Department of Human Services |
| **DOC** | Department of Corrections |
| **DPA** | Department of Public Assistance |
| **DPH** | Dept of Public Health |
| **DPW** | Department of Public Welfare |
| **DSM-IV-TR** | Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision |

| | |
|---|---|
| **DX** | Diagnosis |
| **EAC** | Extended Acute Care |
| **EBP** | Evidence Based Practice |
| **EEC** | Emergency Evaluation Center |
| **EMR** | Electronic Medical Record |
| **EMS** | Emergency Medical Services |
| **EPIC** | DBHIDS Evidence-Based Practice and Innovation Center |
| **EZ** | Empowerment Zone |
| **FAS** | Fetal Alcohol Syndrome |
| **FQHC** | Federally Qualified Health Center |
| **FSAU** | Faith Spiritual Affairs Unit |
| **FBS** | Family Based Services |
| **FF** | Family Focused |
| **FFS** | Fee f or Service |
| **FIR** | Forensic Intensive Recovery |
| **FY** | Fiscal Year |
| **HFW** | High Fidelity Warp |
| **HIE** | Health Information Exchange |
| **HIPAA** | Health Insurance Portability and Accountability Act |
| **HIV/AIDS** | Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome |
| **HMO** | Health Maintenance Organization |
| **ICM** | Intensive Case Management |
| **ICRR** | Intensive Community Residential Rehab |
| **IDDT** | Integrated Dual Disorders Treatment |
| **IDS** | Intellectual disAbility Services (formerly MRS) |
| **IEP** | Individualized Education Plan |
| **IOP** | Intensive Outpatient Program |
| **LGBTQI** | Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex |
| **LOC** | Level of Care |
| **LTSR** | Long Term Structured Residence |
| **MA** | Medical Assistance |
| **MAT** | Medication Assisted Treatment |
| **MAT** | Medication Assisted Treatment Programs |
| **Max CRR** | Maximum Community Residential Rehab |
| **MET** | Mobile Emergency Team |
| **MH** | Mental Health |
| **MHOP** | Mental Health Outpatient |
| **MHP** | Mental Health Professional |
| **MHW** | Mental Health Worker |
| **MT** | Mobile Therapist |
| **NA** | Narcotics Anonymous |
| **NAMI** | National Alliance for the Mentally Ill |
| **NIAC** | Network Improvement and Accountability Collaborative |
| **NIATx** | Network for Improvement of Addiction Treatment |
| **OAS** | Office of Addiction Services |
| **OESS** | Office of Emergency Shelter Services (see OSH) |
| **OMH** | Office of Mental Health |
| **OP** | Outpatient |
| **OSH** | Office of Supportive Housing (replaces OESS) |
| **OTC** | Over the Counter Mediation |
| **OVR** | Office of Vocational Rehabilitation |
| **PCBH** | Personal Care Boarding Home |
| **PCH** | Personal Care Home |

| | |
|---|---|
| **PCP** | Primary Care Physician |
| **PCPC** | Pennsylvania Client Placement Criteria |
| **PEP** | Psycho Educational Program |
| **PIP** | Performance Improvement Plan |
| **PHA** | Philadelphia Housing Authority |
| **PHI** | Protected Health Information |
| **PHP** | Partial Hospitalization Program |
| **PDR** | Progressive Demand Residence |
| **PIN** | Parents Involved Network |
| **PPA** | Pennsylvania Protection & Advocacy Agency |
| **PPLA** | Philadelphia Peer Leadership Academy |
| **PPD** | Philadelphia Police Dept. |
| **PR** | Provider Relations; Public Relations |
| **PRN** | Pro re nata ("In the Circumstances", or commonly "As Needed") |
| **PTSD** | Post Traumatic Stress Disorder |
| **QI** | Quality Improvement |
| **RC** | Resource Coordinator |
| **RINT** | Residential inpatient Non-Hospital Treatment |
| **RITA** | Residential Intensive Treatment Alternatives |
| **RT** | Residential Transformation |
| **RTF** | Residential Treatment Facility |
| **SA** | Substance Abuse |
| **SAMHSA** | Substance Abuse & Mental Health Services Administration |
| **SBCM** | School Based Case Management |
| **SCOH** | Services to Children in their Own Home |
| **SIL** | Supported Independent Living |
| **SLA** | Supported Living Arrangement |
| **SP** | Special Project |
| **Spec Ops/CJ U** | Special Operations and Criminal Justice Unit |
| **SRO** | Single Room Occupancies |
| **SS** | Social Security |
| **SSA** | Social Security Administration |
| **SSDI** | Social Security Disability Income |
| **SSI** | Supplemental Security Income |
| **SSLA** | Specialized Supported Living Arrangement |
| **STS** | School Therapeutic Services |
| **TANF** | Temporary Assistance to Needy Families |
| **TC** | Treatment Court |
| **TCM** | Targeted Case Management |
| **TEP** | Transitional Employment Program |
| **TSS** | Therapeutic Staff Support |
| **TSSA** | Therapeutic Staff Support Aide |
| **TX** | Treatment |
| **WRAP** | Wellness Recovery Action Plan |

# Appendix D:  Information Source Key Definitions

**(AM)**   **Agency Manual –** a binder of information collected and maintained by the agency.  This information describes agency practices, etc.

**(CR)**   **Clinical Records** - A written record capturing all aspects of the person's clinical care; this record would include, but is not limited to, assessments and evaluations, recovery/resilience plans, progress notes, medication management notes, etc.

**(ELI)**   **Executive Level Interview** – NIAC team member(s) will have a dialogue with executive level staff at the agency to ascertain information about the agency's alignment with the *Practice Guidelines.*

**(LR)**   **Living Review** - This activity employs a "360" degree review of a person's involvement with a provider, which allows for a full exploration of the personal experience of the relational, recovery and resilience aspects of care.  Interviews with the person receiving services, their primary staff person and the primary staff person's supervisor, as well as a review of the person's clinical chart will take place.  A final meeting with the primary staff person concludes this process to provide collaborative feedback, specifically focusing on strengths. The Living Review may be modified at times, particularly for different LOCs.

**(O)**   **Observation** – Information gathered through tours and the agency's general atmosphere of the milieu.

**(PS)**   **Parent Survey** – A standardized questionnaire is utilized to obtain feedback from parents.

**(PCS)**   **Peer Culture Survey** - The use of an instrument designed to record the thinking and experiences of participants and staff regarding the quality of peer culture, peer leadership and peer support within a program.

**(PDG)**   **Peer Discussion Group** - CPS led discussion group facilitated by DBHIDS.

**(SA)**   **Self-Appraisal** – A provider-completed tool to determine the alignment of program practices to the *Practice Guidelines*.

**(SF)**   **Staff File –** The employee's personnel file, to include the employee's performance evaluation.

**(SFG)**   **Staff Focus Group** - Information provided in a group setting by staff members of the agency.

**(SR)**   **Staff Report** - Information received from an agency staff member; this could be in the form of a dialogue or in a written format.

**(SN)**   **Supervision Notes and Logs -** Evidence to the methods, quality, frequency and outcomes of supervision.

**(TM)**   **Training Materials** - Any materials or documentation used for trainings; curricula, DVD, PowerPoint, books, tests, etc. This will also include the agency's training plan and corresponding training opportunities and schedules.

**(TS)**   **Tracking System** - Is a database with the tracking of information, which may include but are not limited to, the tracking of same-day appointments, no show rates, the measuring of effectiveness of services, engagement, accessibility, follow-up, re-entry, etc.

**(WP)**   **Written Policy** - Written policies serve as evidence that the organization has created sound administrative and clinical procedures.  Implementation thereof, in addition to determining the agency's alignment with the *Practice Guidelines,* is a critical component to be examined.

# Appendix E: Network Inclusion Criteria Agency Self-Appraisal

**Instructions**: The questions within the Agency Self-Appraisal are designed to guide you through a process of examining your agency practices to determine how you align with the Practice Guidelines. Based on many factors, including culture, programs may take different approaches to align with the Practice Guidelines. The implementation of the Practice Guidelines should be viewed as a developmental process; therefore it is expected there will be both strengths and challenges identified. The use of the word "people" references adults, adolescents and children. It is recommended for various stakeholders to be involved in the completion of this process: executive, supervisory and direct care staff as well as people receiving services within your organization. This Self-Appraisal will be used as a starting point for the NIAC review. It will become part of the many sources of information that will provide a comprehensive view of your agency. *Please limit the response to five pages in length.*

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## Foundations of Excellence in Service Delivery

A. What steps have you taken to date to infuse the DBHIDS Practice Guidelines into the culture of your agency?
   o How do you intend to continue this work?

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## Domain 1: Assertive Outreach and Initial Engagement

A. How does your organization provide easy access for people seeking services (e.g., same day appointments, flexible hours*)? (\*Corresponds to Domain One: Standard A: Practice Three of the NIC.)*
   o What transportation resources do you provide?
   o What type of access/resources for childcare do you provide?

B. What partnerships have you established to educate and create cross-system collaboration with emergency responders (e.g., local police) in addressing the needs of people with behavioral health issues? (*\*Corresponds to Domain One: Standard B: Practice One of the NIC.)*

C. What partnerships have you established with community organizations (e.g., recreation centers, juvenile justice organizations, housing providers, faith-based groups, schools, etc) to identify people who may benefit from behavioral health support? *(\*Corresponds to Domain One: Standard B: Practice Two of the NIC).*

D. How does your organization identify and address the unmet behavioral health needs of those in the community (e.g., public awareness campaigns)? *(\*These questions correspond to Domain One: Standard B: Practice Three of the NIC).*
   o How will this outreach include school staff?

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## Domain 2: Screening, Assessment, Service Planning and Delivery

A. What empirically supported screening and assessment tools do you utilize in your clinical practice?
   o What specific tools are administered to assess for trauma?

B. How do you actively reach out to and include families and significant others in the recovery/resilience process?

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**Domain 3: Continuing Support and Early Re-Intervention**

A. What processes are in place to ensure that continuing support planning is driven by the individual receiving services and begins at intake?

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**Domain 4: Community Connection and Mobilization**

A. What opportunities for leadership do you provide to people receiving services in your organization? *(*Corresponds to Domain Four: Standard A: Practice Two of the NIC).*

B. How is community inclusion fostered at your agency (e.g., connecting individuals to employment opportunities in the community)? *(*Corresponds to Domain Four: Standard B: Practice One of the NIC).*

C. Discuss the current reciprocal agreements that are in place with community partners? *(*Corresponds to Domain Four: Standard B: Practice Two)*
   o What is the evidence of this collaboration?

D. How do you coordinate physical and behavioral health care? *(*Corresponds to Domain Four: Standard C: Practice One of the NIC).*

# The Framework

| 4 Domains:<br><br>7 Goals: | Domain 1:<br>Assertive outreach and initial engagement | Domain 2:<br><br>Screening, assessment, service planning and delivery | Domain 3:<br>Continuing support and early re-intervention | Domain 4:<br>Community connection and mobilization |
|---|---|---|---|---|
| **A. Provide Integrated Services** | | | | |
| **B. Create an atmosphere that promotes strength, recovery and resilience** | | | | |
| **C. Develop inclusive, collaborative service teams and processes** | | **10 Core Values:** | | |
| **D. Provide services, training and supervision that promote recovery and resilience** | | In each domain, all of the goals for the delivery of effective care are pursued through **strategies**. Each of these strategies reflects one or more of the 10 core values that drive this work: | | |
| **E. Provide individualized services to identify and address barriers** | | 1. **Strength-based approaches that promote hope**<br>2. **Community inclusion, partnership and collaboration**<br>3. **Person- and family-directed approaches**<br>4. **Family inclusion and leadership**<br>5. **Peer culture, support and leadership** | | |
| **F. Achieve successful outcomes through empirically supported approaches** | | 6. **Person-first (culturally competent) approaches**<br>7. **Trauma-informed approaches**<br>8. **Holistic approaches toward care**<br>9. **Care for the needs and safety of children and adolescents**<br>10. **Partnership and transparency** | | |
| **G. Promote recovery and resilience through evaluation and quality improvement** | | | | |

# Appendix G- I: Data Collection for Strength-Based Assessments and Evaluations

*This appendix references Domain 2:  Screening, Assessment, Service Planning and Delivery: Standard B*

***Information to be collected for an Assessment:***
Each Assessment must be LEGIBLE and will contain, at the minimum, the following information:

- Behaviorally defined presenting challenges

- Comprehensive medical history

- Identified allergies (drug, food and environmental)

- Comprehensive psychiatric history

- Comprehensive substance use history

- Comprehensive history of **past** medications

- Comprehensive documentation of **current** medications (to include at a minimum, the dosage, frequency, prescribing physician and purpose)

- Comprehensive educational history

- Comprehensive developmental history, particularly for children and individuals diagnosed with an intellectual disAbility

- Comprehensive spiritual history

- Comprehensive nutritional history

- Comprehensive vocational/occupational history

- Comprehensive legal history

- Comprehensive sexual history

- Past/Present history of aggression/suicidality/abuse, when identified

- Detailed summary of the person's support system

- DSM IV-R five (5) axes diagnosis

- Identified initial goals for treatment. Goals must be realistic, individualized and
  - appropriate

- Comprehensive review of the individual's strengths

- A mental status exam

- Evidence of initial discussions around continuing support planning

- Documentation that provides evidence that the assessment was completed within time frame indicated by Agency policy

- Signature of the person who completed the Assessment and corresponding date(s) in which the Assessment took place

# Appendix G- I: continued

*__Information to be collected for a Comprehensive Biopsychosocial Evaluation (CBE), as indicated in the Utilization Manual is as follows and can be found at:__*
*(http://www.dbhids.org/assets/Forms--Documents/UMCh1CLinicalAssessment2-29-08.pdf)*

- Presenting Challenge

- History of Present Challenge

- Developmental History: For children and adolescents, the developmental domains of physical growth, social, emotional, cognitive, and speech/language should be enumerated. Other areas include: physical development and medical history; school or work functioning; substance use or dependence (including age of first use and age of continued use); emotional development and temperament; peer relations; family relationships; conscience and values; interests, hobbies, and talents; unusual or traumatic events

- Behavioral Health Treatment History

- Medical History, Including Allergies

- Family Medical History

- Social History: (e.g., includes a summary of living arrangements, relationships, guardianship issues, and involvement with governmental social agencies, if any, as well as the status of involvement.)

- Occupational/Vocational History

- Educational History

- Individual/Family Behaviors (i.e. during interview process)

- Mental Status Exam

- Assessment of substance use

- Collateral Information

- Laboratory Tests

- Data from Structured Tools

- Biopsychosocial Formulation: The formulation interweaves the biological, psychological and social factors contributing to the individual's challenges with those that indicate potential success in a treatment setting. The comprehensive formulation leads to accurate diagnosis and to appropriate recovery/resilience planning. Components of the formulation include predisposing, precipitating, perpetuating and protective factors. The individual's and family's personal strengths and community supports are important to consider in the formulation.

- DSM Diagnosis (Axis I – V)

- Recommendations for Intervention

*__\*\*\*Additional items to be explored in the CBE:__* the individual's sexual history, to include the individual's sexual orientation and gender identity; the individual's legal history; etc.

# Appendix G- I: continued

***Information to be collected for a Comprehensive Biopsychosocial Re-Evaluation (CBR), as indicated in the Utilization Manual is as follows and can be found at:***
*(http://www.dbhids.org/assets/Forms--Documents/UMCh1CLinicalAssessment2-29-08.pdf)*

- Clinical Justification for CBR
- Demographic Information:
- Mental Status Exam (MSE)
- Assessment of substance use, (when clinically indicated)
- Collateral Information
- Laboratory Tests, (when clinically indicated)
- Data from Structured Tools, (when clinically indicated
- Medical Issues
- Recovery/Resilience Plan Review
- Updated Clinical Formulation
- DSM Diagnosis (Axis I – V)
- Recommendations for Interventions

***Recommended Prompts to Ascertain the Information for Assessments, CBEs and CBRs in a Strength-Based Manner:***

- **Personal Strengths:** *e.g., What are you most proud of in your life? What is one thing you would not change about yourself?*
- **Interests and Activities:** *e.g., If you could plan the "perfect day," what would it look like?*
- **Living Environment***: e.g., What are the most important things to you when deciding where to live?*
- **Employment:** e.g., *What would be your ideal job?*
- **Learning***: e.g., What kinds of things have you liked learning about in the past?*
- **Trauma:** *e.g. Have there been people in your life who have hurt you in some way in the past (physically, emotionally, sexually)? In relationships with other previous or current therapist(s) and/or doctor(s), have you ever been treated inappropriately or in ways that were harmful to you (e.g., poor boundaries, sexual inappropriateness, physical abuse, etc.)?*
- **Safety and Legal Issues:** *e.g., Do you have any legal issues that are causing you problems?*
- **Financial:** e.g., *Would you like to be more independent with managing your finances? If so, how do you think you could do that?*
- **Lifestyle and Health:** e.g., *Do you have any concerns about your overall health? What are those concerns? Tell me a bit about your behavioral health: What does a good day look like? A bad day?*
- **Choice Making:** e.g., *What are the some of the choices that you currently make in your life? Are there choices in your life that are made for you?*
- **Transportation:** e.g., *How do you currently get around from place to place? What would help?*
- **Faith and Spirituality:** e.g., *What type of spiritual or faith activities do you participate in?*
- **Relationships and Important People***: e.g., Who is the person in your life that believes in you? In what ways does this person convey this belief in you?*
- **Hopes and Dreams:** *e.g., Tell me a bit about your hopes or dreams for the future.*

*(Tondora, 2005)*

# Appendix G – II: Data Collection for Progress Notes

The following information, at a minimum, must be captured in a progress note:

- Time and date of entry (e.g.,"3:00pm – 4:00pm")
- Type of service is denoted (e.g., individual, group, family)
- Assessment of behavior, mood, and interactions with others
- Documentation of staff intervention(s) and the individual's response(s) to those staff interventions
- Depiction of progress towards (or lack thereof) recovery/resilience plan goals, and any other pertinent clinical information
- When applicable, reference medical conditions and/or lab work
- Follows a format (e.g., SOAP, DAP, BIRP, PAIR) as indicated by agency policy.
- Documentation of a plan for continued care. **Note**: A plan is NOT merely the date and time of the next appointment.
- Documented evidence of follow-up on plan established at last session
- An original and legible signature of the clinician, along with job title and their credentials.
- Evidence of the integration of treatment team members
- Notes are LEGIBLE

***Group Notes Must Also Contain the Following, at a Minimum:***

- Topic of the group session
- An individualized response to the session from the person receiving services
- An original and legible signature
- Group note contains comprehensive documented evidence of the nature and extent of the group session(s) as related to the recovery/resilience plan

*Note: When interns/graduate students are used in an agency, progress notes must be cosigned by a staff member that meets the credentialing requirements for that corresponding position.  For instance, if an intern works as a therapist in an Outpatient Psychiatric Clinic and the intern does not meet the minimum requirements for a Mental Health Professional, then a staff member that meets the credentialing requirements of a Mental Health Professional must cosign the intern's notes.  Please reference the Provider Manual for additional details.* **http://www.dbhids.org/assets/Forms--Documents/CBH/Provider-Operations-6.pdf**

# Appendix G -III: Data Collection for Medication Monitoring

*This appendix references Domain 2:  Screening, Assessment, Service Planning and Delivery: Standard D*

The following information, at a minimum, must be captured in a medication monitoring session:

- The name of individual prescribed the medication

- The name & dosage of medication including all over-the-counter medications, home remedies & herbal supplements – as dosages change, the note shall indicate the rationale for the change

- The date of each medication order

- The means of administration

- The medication schedule

- The reason for the medication, to include the individual's diagnosis

- The effectiveness of medication

- The adverse effects of medication

- Written consent of the individual and/or legal guardian

- Acknowledgement and adherence of off-label prescribing (in accordance with CBH Bulletin #10-33)

- Acknowledgement and adherence of the policy for the Screening for and Treatment of the Components of Metabolic Syndrome (in accordance with CBH Bulletin #07-07)

- Detail regarding who administers the medication.  (e.g., a healthcare provider administers the medication or a written prescription is provided)

- Collaboration with primary care physicians regarding prescribed psychotropic agents, with consent

- Involvement of any other professionals: home psychiatric nurse, etc.

- Parents and individuals who administer or supervise the use of medication should be involved

# Appendix G - IV: Data Collection for Continuing Support Planning

*This appendix references Domain 3: Continuing Support and Early Re-Intervention: Standard A*

***Information to be collected for Aftercare and Discharge Plan components, as indicated in the Utilization Manual as follows:*** *http://www.dbhids.org/assets/Forms--Documents/UMCh5AftercareDischargePlanning2-29-08.pdf*

***Please refer to the DBHIDS website for details. However, in addition to these requirements, continuing support planning documentation must also contain the following:***

- Individualized crisis plans – to include the prevention and management of potential crises

- The identification of recovery capital including skills and strengths

- Next steps to be taken by the individual in their recovery journey

- Community supports

- Identification of natural supports, both personal and supportive

- Identification of protective factors

- Medical concerns, issues and alerts

- A comprehensive listing of upcoming appointments (to include the date/time of appointment, place, identified person with whom the appointment is with, etc), including but not limited to behavioral health services – this may include community-related events/activities

- Signatures of the individual receiving services AND signature of the of psychiatrist or clinical director

- Axis I – V (Initial and Final)

- Continuing support plans for those individuals transitioning to another level of care (LOC) (within an agency or outside of an agency) include:
  - Achievements made in the current program (progress and outcomes)
  - Diagnostic and assessment information
  - Description of the course of services to that point
  - Unique considerations (language, physical, etc.)
  - Primary care physicians and other medical providers
  - Current recovery/resilience plan goals
  - A plan for follow-up with individuals and families is established before they leave services

# Appendix G - V: Data Collection for Quality of Care and Outcome Measures

***Suggested Items to Measure:***

- No show rates

- Level of program participation (this will look different per LOC)

- Wait times:
    - Between program inquiry (e.g., phone call, walk-in, referral) and intake
    - Time between intake and first appointment

- Percentage of people who return for a second appointment (not applicable for every LOC)

- The duration of service delivery

- Frequency  and duration of re-entry to the same LOC

- Frequency and use of community resources

- Degree to which families/allies are engaged in services

- Progress towards attainment of recovery/resilience goals

- Outcomes associated with referrals to external professional and community-based resources are tracked.

- Service participants, alumni, family members/allies and other stakeholders are afforded frequent opportunities to provide qualitative and quantitative feedback concerning quality of care.

- Efforts to expand service access, optimize initial engagement, and enhance retention rates are routinely assessed and agency processes are modified, if necessary.

# Appendix H: Trainings

*Staff need continual trainings in order for the agency to strive for excellence in service delivery. DBHIDS has and will continue to recommend areas for organizational and staff development it sees as relevant to the overall mission of the DBHIDS, the provider community, people receiving services and the community.  ***Please note that in addition to the required trainings indicated in the Community Behavioral Health (CBH) Credentialing Manual and CBH Bulletins, as part of the NIAC review process additional trainings will need to occur for staff, as identified within this Appendix.*

## Understanding and full execution of the Practice Guidelines
The DBHIDS and provider community have received introductory and specialized training in the *Practice Guidelines*.  The current training and staff development task is the deepening of their application in practice.  It is recommended that ongoing training and supervision reflect this system need.

## Evidence-based, evidence-informed and agency adopted best practice
*Supervisors must receive specialized training in the evidence-based practices (EBPs) adopted by the agency in order to guide their implementation.*  Agency adopted practices (whether it is EBPs or local adopted practices) require that all staff be introduced, coached and supervised in their adoption and application.

## Trauma-informed Treatment Services
*Providers must demonstrate evidence of trauma-informed staff training about trauma and violence issues, and how to provide treatment and care to individuals within their specific service settings who have experienced or are experiencing trauma or violence. Evidence must include the background and experience of the trainers and evidence of ongoing supervision and consultation.  (Practice Guidelines: Appendix D)*

## Integration of physical and behavioral healthcare
Attention to the integration of behavioral, medical and social aspects of those receiving services is a foundation to the *Practice Guidelines* and is emerging as a key to success in the current healthcare environment.

## Accountable Care Act
With the passage of this law, its understanding and implications for program and staff development are important.

## Family Resource Network Best Practice Guidelines
These guidelines provide direction to agencies regarding the inclusion of family and other significant people within the recovery/resilience process of their loved ones.

## DBHIDS policies and best practices for services to LGBTQI people
*It is required that regular training and skill-building opportunities, conducted by specialists who work with people in LGBTQI communities, be a part of the staff development program for all agencies.   Other requirements include: Two annual six-hour training days that address meeting the clinical needs of LGBQ as well as transgender, gender non-conforming and individuals who are Intersex.* (*Practice Guidelines:  Appendix G)*

# Recommended Documentation for Training

## 1.  Documentation of provider in-service training curricula
The provider should maintain documentation of all in-service trainings offered and conducted (mandatory and ongoing). This documentation should fully reflect the _content_ and _attendance_ of the trainings.

# Appendix H, continued:  Recommended Documentation for Training

2.  **An agency-wide annual training plan should be in place, and should include the following:**
   - An annual assessment of agency training needs <u>and</u> a written training plan based on the results of the assessment, with input from individuals/and families served.
   - A calendar of scheduled mandatory and ongoing in-service trainings, as well as other relevant training opportunities
   - The training calendar should be at least a 12-month calendar and should reflect training times that are practical for all employees.

3.  **Documentation for each training event should include:**
   - **Training materials**: *The full content of the training should be clearly evident.*
     - Instructor's name, title and credentials
     - Number of training hours
     - Outline/agenda
     - Materials used during the training, such as PowerPoint, video, etc.
     - Written materials, handouts, or any other materials that were distributed
     - *Copies of reading materials alone are not adequate without supporting documentation of how the training was conducted, such as an outline or agenda.*

   - **Attendance**:  A sign-in sheet must be maintained for each training that includes: training title; date of training; beginning and end times; number of training hours; location; instructor's name, title, credentials and signature; employer's name and signature; and employees' names and signatures.

4.  **Feedback**
The provider should develop a system for obtaining employee feedback at the end of each training program.  This should measure the effectiveness of the training, instructor, materials, and suggestions for additional trainings.

5.  **Documentation for each employee**
Individualized documentation for each employee should be maintained. This should be in the employee's personnel file, or in a training file that is maintained for each employee.

   - An annual individualized learning plan should be in place for each employee that includes:
     - An annual written training plan appropriate to the employee's skill level and educational background, to include all projected (at least one year) mandatory and recommended trainings;
     - The employee and the supervisor should sign the plan.

   - Documentation of completed trainings for each employee must include:
     - An original or verified copy of the training certificate (if available);
     - A log of completed mandatory, ongoing, and level of care specific trainings.  The log should include training due date, the employee's name, department, name of training, description of content, name of instructor, employer's signature, employee's signature, date of the training, number of hours, and type of credit earned (CE, etc.);
     - Any outside training, continuing education, or other professional development should be reflected in the employees file. This should include the training certificate.

*The above documentation satisfies the requirements of:*
*Medical Assistance Bulletin (#01-01-05), Commonwealth of Pennsylvania, Depart. of Public Welfare*
*Commonwealth of Pennsylvania — Department of Health — Title 28, Chapter 704.11.*
*Commonwealth of Pennsylvania — Department of Health — Title 55, Chapter 3800.58.*
*\*CBH Credentialing Manual, 2004*

# Appendix I.  Recovery/Resilience-Oriented Clinical Supervision

**1.  Supervision Policy, Practices and Documentation**
The provider shall establish a supervision policy that will ensure that supervision will be conducted regularly, across all levels of care and for all clinicians, including all recovery/resilience staff, certified peer specialists and all other mental health and substance use staff providing direct care.  The provider shall determine the frequency, duration, and modalities that will best support the supervisee in providing effective services, the details of which shall be clearly defined.  It is essential that the policy and practice reflect Recovery/Resilience-Oriented Clinical Supervision *and* Administrative Supervision.  All supervision must be documented.   While a supervision policy may indicate the ideal circumstances and expectations of the supervision process, it is expected that staff persons requiring increased support, will receive supervision reflecting these needs.

**2.  Supervision within the context of the *Practice Guidelines***
Supervision is emphasized within the seven goals, ten values and four domains of the *Practice Guidelines*.  Please reference **Appendix F** in this document for an illustration of the Framework of the *Practice Guidelines*.  These values, goals and domains establish a change agent role for supervision in facilitating program and staff development at the agency level.  Supervisors are in a unique position to develop this emphasis of practice.  Supervision policies and practices should reflect this role in transforming services.

**3.  Supervision Requirements: All Levels of Care**
- Supervision must occur regularly for all direct-care personnel; the frequency and duration of which will be determined on the provider.  For those programs in which state and/or federal regulations exist, the state and/or federal regulations shall determine the *minimum* acceptable supervision provision.
- Supervision should support a trauma-informed approach to assessment and service delivery.
- The evidence-based practice(s) that the agency has adopted should be supported during supervision. *If an agency has received specialized training from DBHIDS in an empirically-informed practice, the fidelity and integrity of the selected approach must be maintained.*
- Supervision should be supportive and strength based.
- Supervision for child and/or adolescent service staff must include a review and discussion of the worker's caseload at least once every month, at a minimum.  In addition to discussing the progress of each child or adolescent, the supervisory session should review implementation of the recovery/resilience plan, including specific interventions; integration of efforts with other professional team members; efforts to collaborate with the family and to apply CASSP principles; outcome of action steps planned in the preceding supervisory session; and projected action steps to the next supervisory session.

**4.  Family Resource Network (FRN) *Family Involvement Best Practice Guidelines (*** *Practice Guidelines:
Appendix I)*
- All therapists, case managers, and other assigned clinicians who work with significant people (SP) of those receiving services have training and experience and receive ongoing clinical supervision.
- Clinicians have at least one year of supervised family/SP liaison work, or they have received training in outreach to SPs (especially family members), engaging SPs in support of the person's recovery efforts, are knowledgeable of available resources for SPs (especially families), and have demonstrated competence in these areas.
- All clinicians working with families and SPs receive at least monthly ongoing clinical supervision that includes discussions of SP involvement and support issues.

# Appendix I , continued:  Recovery/Resilience-Oriented Clinical Supervision

**5. Documentation of Clinical Supervision**
- Supervision logs *and* notes should be maintained for all direct care staff.  In order to support staff development, these documents should be searchable by supervisee name.

- A supervision **log** should be maintained for each clinician. This should include:
  - Supervisee's name
  - Supervisor's name
  - Level of care
  - Modality (individual or group)
  - Date and times of each session
  - Caseload
  - Hours worked per week
  - Additional requirements for BSC and TSS supervision logs:  Must indicate the number of ASD and non-ASD individuals

- Individual supervision **notes** should include the following information:
  - Supervisor's name, date and signature
  - Supervisee's name, date and signature
  - Level of care
  - Date and time of session
  - Exact clock hours of session
  - Location
  - A narrative descriptive summary of the points discussed during the session
  - Additional requirement for BSC and TSS supervision notes:
    - For those supervision sessions where ASD services are discussed, this must be indicated in the context of the note
    - TSS Onsite Assessment and Assistance notes must be maintained with supervision notes

- Group supervision notes should include the following information:
  - Supervisor's name, date and signature
  - Sign in sheet for supervisees
  - Level(s) of care
  - Date and time of session
  - Exact clock hours of session
  - Location
  - A narrative descriptive summary of the points discussed during the session

## Appendix J: Family Resource Network Best Practice Standards Involving Participant-Identified "Significant People" In Mental Health Treatment and Recovery Programs

1. **INVOLVING PARTICIPANTS IN IDENTIFYING SIGNIFICANT PEOPLE IN THEIR LIFE AND GIVING PERMISSION TO CONTACT SP's WHO ARE IMPORTANT TO RECOVERY**

   During the intake process or soon after, **all participants are encouraged by staff members to identify and provide "family friendly" signed releases for SP's who may have a positive or negative impact on their recovery**. Staff members also help identify people who may help or hinder the participant's treatment and recovery.

   After regular clinical staff (for example, therapists and case managers) are assigned to a participant, these staff members continue to make efforts to help participants identify people who can be significant to their recovery, as well as continuing to make efforts to obtain permission to talk to family members and other SP's who the clinician sees as important to the participant's recovery. This is *not* a one-shot, "mention once at intake" process.

2. **INITIAL CONTACTS WITH SP'S**
   <u>Assigned</u> staff members continue the collaborative process of identifying important SP's, and **with the participant's approval contacts them <u>by phone</u> as soon as possible to answer questions, seek information, and ask for their involvement and support in the participant's recovery**.

   It is emphasized that clinicians contact significant people "by phone" due to the difficulty many family members and other SP's have in making a workday trip to the clinician's office—especially if reliable transportation is not available, the SP has few financial resources, and/or has difficulty getting time off from his/her work.

   A primary purpose for the initial phone call is to ask significant people about their concerns, to <u>offer information about the agency and its programs, to offer information about sources of family support and education, and to ask for support in assisting the participant in his/her recovery</u>.

   The assigned staff should also ask for any critical information on a participant's past treatment problems and successes that may be vital to his/her recovery.
   <u>The inability or unwillingness of family members or other SP's to travel to the agency site for personal interviews is *never* a reason for the absence of family contacts or continued outreach</u>.

   **NOTE**: Listing "emergency contacts" for participants is **not** "family involvement" unless those contacts are called routinely and not just in emergencies. "Emergency contacts" are by definition only for emergencies, and are usually not for helping participants in their recovery. Lists of emergency contacts are not lists of SP's.

3. **INCLUDING SP'S IN RECOVERY AND TREATMENT PLANNING**

   **Provider clinicians include appropriate family members and other significant people in treatment team recovery planning and encourage their ongoing efforts to help the participant meet recovery goals.**

Assigned clinicians make the earliest possible participant-approved arrangements for <u>family members and other SP's to be included in at least some treatment team recovery and discharge planning meetings concerning the participant's recovery</u>.

Families and other SP's are included in making contingency plans and other planning meetings that may have an impact on SP's and call for their understanding and/or cooperation. <u>With participant permission, results of such meetings should be communicated to SP's who couldn't attend but are a vital part of the participant's recovery</u>. **This is especially important when changes in service such as discharges or transfers are planned.**

**4. RESOURCES FOR SIGNIFICANT PEOPLE**

Provider staff members **offer ongoing support and educational resources or referrals to families and other involved SP's (as opposed to family therapy).**
This may include discussions of the participant's diagnosis (with participant permission) and the implications for treatment and recovery.
The staff offers families written materials concerning family resources (such as the FRN Family Resources Packet) and other up-to-date information.

5. **DOCUMENTATION**
**Provider clinicians document all steps taken regarding SP's in clinical progress notes.**
Documentation includes releases, efforts to obtain releases, staff contacts of any kind with SP's, and staff/participant plans for future and ongoing involvement of SP's. <u>Documentation includes explanations of why there is no staff contact with any SP, if that is the case</u>.

Documentation includes timely updates and descriptions of efforts involving SP's <u>in the progress notes</u>. <u>The documentation provides enough detail to allow quality of care reviewers to judge the quality and amount of SP-related effort</u>.

6. **QUALITY ASSURANCE/QUALITY IMPROVEMENT (QA/QI)**
**Provider agencies routinely review documentation of the inclusion and support of participants' significant people as part of their <u>continuing</u> QA/QI efforts**.

"Providers routinely review at least a sample of randomly-chosen records looking for evidence of documentation of all staff practices listed above, including identification of SPs and <u>proactive</u> and timely outreach to all SPs with releases in all agency programs. Program staff members are made aware of strengths and challenges of the documentation in a timely fashion, and any problems are addressed promptly and results/improvements documented."

Providers have regular meetings that include administrative level staff to review the overall effectiveness of FI efforts, and to plan and implement improvements.

Providers regularly survey at least a sample of participants, staff members, and significant people and ask them about their awareness of specific practices occurring (To an SP: "Did a staff member call you within two weeks of your participant being admitted to the day program?"), and their level of satisfaction with FI practices and policies. Since most people in human services surveys report high levels of satisfaction no matter what, <u>satisfaction surveys are **not** a substitute for finding out what practices are actually occurring</u>.

7.  **TRAINING AND SUPERVISION**
    **All therapists, case managers, and other assigned clinicians who work with significant people of participants have had adequate training and experience, and receive ongoing clinical supervision.**
    Clinicians have at least one year of supervised family/SP liaison work, or they have received training in outreach to SP's (especially family members), engaging SP's in support of the participant's recovery efforts, and knowing of and offering resources for SP's including families-- and the clinicians have demonstrated competence in these areas.

    All clinicians working with families and SP's receive <u>at least monthly ongoing clinical supervision</u> that includes discussions of SP involvement and support issues.

8.  **INFORMING SIGNIFICANT PEOPLE OF AGENCY AND PROGRAM SERVICES**
    **Provider staff familiarize SP's with agency and program services** through conversations (asking for any questions that SP's may have) and literature.  SP's are informed of the procedure for appealing decisions with which they disagree.  SP's are informed who program administrators are. Any students or others in training inform SP's of their student status and who their supervisor is (as required by professional ethics).

9.  **SP INPUT & INVOLVEMENT IN PROGRAM & POLICY DECISIONS**
    Staff proactively recruit family representatives to serve on policy or feedback committees, and to participate in QA/QI interviews and surveys.

FRN/7-11

# Appendix K:  City of Philadelphia Department of Behavioral Health & Intellectual disAbility Services

## Family and Confidentiality Guidelines

### 1.  Statement

The current standards of confidentiality and/or privacy regulations have long presented a barrier to family members and/or support persons of those receiving services from being fully included and/or recognized within the recovery process and the development of resilience and protective factors in children, adolescents and families. The complexities of the standards often make it difficult when service providers have to enforce the law.

In keeping with the guiding principles of systemic recovery transformation within the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), these guidelines are intended to further promote family inclusion and leadership in all levels of care throughout Philadelphia's behavioral healthcare system, while simultaneously adhering to confidentiality laws & regulations.

### 2. Context

Involving family members or significant person(s) to participate in the recovery/resilience journeys of their relatives and friends when a family member is receiving behavioral health services help to speed recovery and resilience and increase recovery capital. There are, however, occasions when persons receiving services choose not to formally invite or approve the involvement of their families or other supporters. Under these circumstances, confidentiality regulations must be upheld.

However, the absence of a signed release does not preclude the service providers from contacting the family or friends of service recipients in nonconsensual situations (55 PA Code § 5100.32). In the absence of a signed release, service providers may contact families and other supporters when the individual receiving services makes a credible threat of bodily harm to him or herself or to another individual.  The service provider may only release the specific information pertinent to the relief of the emergency. If the individual is receiving addiction treatment services, the service provider may only disclose the threat anonymously to the subject of the threat or to the police.

### 3. Intention

These guidelines are intended to convey the types and extent of communication that can occur between providers and significant others when a signed release of information has not been secured. They also are intended to reinforce the importance of family inclusion and leadership as an established pillar of system transformation. They will provide the means with which to provider agency staff on what is deemed as an acceptable form of inclusion within the realms of confidentiality.

### Recommendations

It is recommend that the following practices be employed by provider agencies to manage collateral contacts with friends and family members of service recipients for whom there are no signed release of information forms. These guidelines are informed by the *Philadelphia Behavioral Health Services Transformation Practice Guidelines for Recovery and Resilience Oriented Treatment* (April, 2011). The

following four guiding principles should be utilized by provider agencies when handling a contact without a signed release of information from the person receiving services:

A. **Listening to Family Members, Key Allies and/or Significant Others without a Release**
   I. There is no legal or clinical reason to refuse to listen to a family member or other significant person who may call to obtain information about the individual receiving services. In the case of an involuntary commitment of someone with a mental health challenge, 55 Pa. Code § 5100.31 (d) states: *Nothing in this chapter shall limit the facility's obligation to attempt to obtain social history and other records necessary to properly treat a person who has been involuntarily committed.*

   II. Staff must still inform the person requesting information that they *may not* confirm or deny the presence of an individual receiving services within a program. This is especially true when the individual is receiving services for addiction challenges. In the case of an individual receiving care within a mental health facility, 55 Pa. Code § 5100.31 (g) states that *the presence or absence of a person currently involuntarily committed to a mental health facility...may be released at the discretion of the director of the facility...when it is clearly in the person's best interest to do so.*

   III. Staff must inform the person(s) requesting information that the provision of general information about a behavioral health challenge is not an indication that someone is receiving care.

   IV. Staff *may* inform the person(s) requesting information that they can listen to them.

   V. Staff should interact with family members or significant others who call seeking information in a professional, courteous and respectful manner.

B. **Giving Resource Information to Family Members, Key Allies and/or Significant Others without a Release**

   I. There is no legal or clinical reason to avoid giving resource information to a family member and/or other significant person. (i.e. the phone number of a support group, a source of information about SSI benefits, etc.)

   II. Staff must still inform the person requesting information, in general and at the onset of the conversation, that they *may not* give any information regarding any individual who may be receiving services. (Exceptions are contained in I and II above)

   III. Staff *may* inform the person(s) requesting information about particular resources that may be of help and/or assistance to them and, in turn, provide information about that resource.

C. **Nonconsensual Release of Information – (Breaking Confidentiality to Protect an Individual from Serious Risk of Bodily Harm or Death)**

   I. Staff *may* and *should* release information without consent by talking to a family member and/or significant persons *only when a release of information is necessary to prevent serious risk of bodily harm or death to the person receiving services or to others. Only specific information pertinent to the*

*relief of the emergency may be released on a nonconsensual basis.* (See 55 Pa. Code § 5100.32 and Section 2 above)

**D. Nonconsensual Release of Information – (Breaking Confidentiality to Protect the Identifiable Victim of Credible Threat of Bodily Harm)**

I. Staff members have a legal duty to warn the identifiable victim of a credible threat of bodily harm when the individual receiving services is making the threat against a family member, friend, or another identifiable person, even if this breaks confidentiality. (See 55 Pa. Code § 5100.32 and Section 2 above)

*\* Note: While these guidelines are also generally applicable to family members and significant others of youth age 14 to 17 years old receiving services who have consented to their own treatment, parents or other legal guardians of children under the age of 14 have rights to information regarding treatment even without a signed release of information. See PA Act No. 2004-147, effective 2005, which governs the somewhat more complex confidentiality rights of minors 14 years of age and older.*

Note:  These Guidelines were reviewed by the Senior Attorney/Privacy Officer, City of Philadelphia Law Department, September, 2012

# Appendix L:  Best Practices for Electronic Medical Records (EMRs)

**Electronic Medical Records Guidelines**
According to the Office of Mental Health and Substance Abuse Services (OMHSAS), electronic documents will be considered sufficient provided that the following conditions are met (*at a minimum*):
- Documents stored are in a Portable Document Format (PDF) or other permanent storage to prevent the alteration of the document.
- Printed copies of electronic records will be promptly available to licensing staff.
- When documents existed originally in paper form are scanned so as to make an electronic record, the original paper record shall be available for (one licensing cycle).
- Electronic database is reasonably secure and accessible by password, etc.
- Electronic signature must be attached to the applicable document; it is not sufficient for a signature to be on a blank page attached to a document.

**Developing a Policy / Planning for Implementation**
Providers should consider the following points in the development of Electronic Medical Record (EMR) policies, selection of an EMR system, and implementation of the system. This is *not* an exhaustive list, but reflects key points of an EMR and Protected Health Information (PHI).

- ➢ **Health Insurance Portability and Accountability Act (HIPAA) must be considered across all areas of EMR and PHI management.**
  - A dedicated HIPAA officer should be assigned to monitor PHI in EMR.
  - Policies around HIPAA specific to EMR must be developed, communicated, and enforced.
  - Appropriateness regarding HIPAA compliance must be considered before any entity or individual is granted access.
  - Levels of access must be determined regarding which employees (clinicians, supervisors, administrators, etc.) will have access to Protected Health Information (PHI).
  - PHI must be secure on all EMR, including, but not limited to, hardware, external and portable devices.
  - Care should be taken to ensure that computer screens do not unnecessarily display PHI.
  - A policy for granting temporary access to licensing bodies, managed care organizations (MCO), and government entities. The visiting entity should not have access to PHI for any individuals other than those they need to view for the purpose of their visit. (Ex. 'MCO A' should not have access to individuals' PHI from 'MCO B'.)

- ➢ **Preparing for the Transition to EMR**
  - The EMR system must support an individualized, person-first approach.
    - The EMR system should adequately capture the uniqueness of the individual receiving services.
    - Drop-downs and check-boxes should be accompanied by fields for narrative or 'free-text' when applicable.

- ➢ **Training and Education**
  - Initial *and* ongoing technical and educational support will be necessary.
  - The current level of proficiency of technology should be considered, with trainings and ongoing support developed accordingly.

**Resources**
- ➢ **U.S. Department of Health & Human Services**

**Security Rule Educational Paper Series**
The HIPAA Security Information Series is a group of educational papers which are designed to give HIPAA covered entities insight into the Security Rule and assistance with implementation of the security standards. Links to individual papers:

- *Security 101 for Covered Entities*
- *Administrative Safeguards*
- *Physical Safeguards*
- *Technical Safeguards*
- *Organizational, Policies and Procedures and Documentation Requirements*
- *Basics of Risk Analysis and Risk Management*
- *Security Standards: Implementation for the Small Provider*

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


**The Privacy Rule**
The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
*>http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html*

The materials below are the HIPAA privacy components of the *Privacy and Security Toolkit* developed in conjunction with the Office of the National Coordinator. The *Privacy and Security Toolkit* implements the principles in ***The Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information*** (Privacy and Security Framework). These guidance documents discuss how the Privacy Rule can facilitate the electronic exchange of health information.

- *Privacy and Security Framework: Introduction*
- *Privacy and Security Framework: Correction Principle and FAQs*
- *Privacy and Security Framework: Openness and Transparency Principle and FAQs*
- *Privacy and Security Framework: Individual Choice Principle and FAQs*
- *Privacy and Security Framework: Collection, Use, and Disclosure Limitation Principle and FAQs*
- *Privacy and Security Framework: Safeguards Principle and FAQs*
- *Privacy and Security Framework: Accountability Principle and FAQs*
- *The HIPAA Privacy Rule's Right of Access and Health Information Technology*
- *Personal Health Records (PHRs) and the HIPAA Privacy Rule*

*> http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/*

***Office of the National Coordinator for Health Information Technology, Federal Health Information Technology Strategic Plan*** *> http://www.healthit.gov/policy-researchers-implementers/health-it-strategic-planning*

➤ **Substance Abuse and Mental Health Services Administration**
*Frequently Asked Questions Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE), Prepared by the Legal Action Center for the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services*
*>http://www.samhsa.gov/healthprivacy/docs/ehr-faqs.pdf*