Network Inclusion Criteria Standards for Excellence

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DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES
DBHIDS.ORG

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Network Inclusion Criteria

Table of Contents

Network Inclusion Criteria 2

Letter from David T. Jones, Commissioner, DBHIDS 6

SECTION I: OVERVIEW 8

- Vision of Network Excellence 8
- Philadelphia Behavioral Health Services Transformation 8
- The Network Improvement and Accountability Collaborative 9
- The Network Inclusion Criteria Domains and an Organizational Focus 10

SECTION II: NIC REVIEW PROCESS AND SCORING 12

- Structure of NIC Domains and Organizational Focus: Standards and Associated Practices 12
- Tabulating the Level of Care Score (LOC Score) 13
- TABLE I: Weightings for Domains and Foundations of Excellence in Service Delivery 14
- Network Recognition Levels 14
- Table II: Network Recognition Levels 15

SECTION III: THE NETWORK INCLUSION CRITERIA (NIC): COMPREHENSIVE DETAIL ON STANDARDS and PRACTICES 17

- Foundations of Excellence in Service Delivery 18
  - Standard A: Creating Excellence in Agency Staffing and Development 18
  - Standard B: Conducting Supervision in a Recovery/Resilience-Oriented Environment 19
  - Standard C: Determining Quality of Care and Outcomes 20
- Domain 1 20
  - Standard A: Promoting Easy Access and Responsive Engagement 20
  - Domain 1: Assertive Outreach and Initial Engagement 22
- Domain 2 23
  - Domain 2: Screening, Assessment, Service Planning and Delivery 23
  - Domain 2: Screening, Assessment, Service Planning and Delivery Standard B: High Risk Behavioral Assessments (Urgent Screening) 24
  - Standard C: Advancing Excellence in Resilience/Recovery Planning and the Delivery of Services 25
  - Standard D: Ensuring Safe and Effective Medication Practices 27
- Domain 3 28

Domain 3: Continuing Support and Early Re-Intervention 28
Domain 4 29
Domain 4: Community Connection and Mobilization 29
Standard B: Strengthening Community Inclusion and Mobilization 30
Standard C: Integrating Physical and Behavioral Health Services 31
Single County Authority (SCA) Addendum 32
Standard A: Increased Practice Alignment for Substance Use Services 32
SECTION IV: APPENDIX 35
Appendix A: References 35
Appendix B: Glossary of Terminology and Language 36
Appendix B continued: Glossary of Terminology 37
Appendix C: Acronyms 44
Appendix D: Information Source Key Definitions 49
Appendix E: Network Inclusion Criteria (NIC): Agency Self-Appraisal 50
The Framework 54
Appendix G-I: Data Collection for Strength-Based Assessments and Evaluations 55
Appendix G- I: continued 56
Appendix G- I: continued 58
Appendix G – II: Data Collection for Progress Notes 60
Appendix G -III: Data Collection for Medication Monitoring 61
Appendix G - IV: Data Collection for Continuing Support Planning 62
Appendix G- V: DBHIDS Mandatory Outcome Measures 63
Appendix H: Training courses 64
DBHIDS Training Learning Hub: Provider Enrollment 65
Understanding and full execution of the Practice Guidelines 65
Evidence-based, evidence-informed and agency adopted best practice 65
Trauma-informed Treatment Services 65
Integration of Physical and Behavioral Healthcare 65
Family Resource Network Family Inclusion 2018 Best Practice Standards 66
Peer Support/Peer Culture Training 66
DBHIDS policies and best practices for services to LGBTQIA communities 66
Health Insurance Portability and Accountability Act of 1996 (HIPAA) 66
Mandated Reporting 67

Recommended Documentation for Training 67
2. Documentation of provider in-service training curricula 68
4. Feedback 68
5. Documentation for each employee 68
Appendix I. Recovery/Resilience-Oriented Clinical Supervision 69
1. Supervision Policy, Practices and Documentation 69
2. Supervision within the context of the *Practice Guidelines* 70
3. Supervision Requirements: All Levels of Care 70
4. Family Resource Network (FRN) Certified Family Inclusion Standards Guidelines (Practice 70
5. Documentation of Clinical Supervision 71
Appendix J: Family Resource Network 2018 Best Practice Standards Involving Participant-Identified "Family" in Behavioral Treatment and Recovery Programs 72
1. Obtain a Release of Information 73
2. Contact the Family 73
3. Offer Ongoing Support, Guidance, and Resources to all Families 74
4. Engage the Participant in Conversation Around Family 74
5. Engage Family in Recovery Planning 74
6. Provide all Staff Regular Training and Supervision Around Family Inclusion 74
7. Formally Monitor Ongoing Staff Family Inclusion Practices 75
8. Collect Regular Feedback from Family 75
9. Recruit Family to Serve on Boards, Committees, or Other Advocacy Groups 75
Family and Confidentiality Guidelines 76
1. Statement 76
2. Context 76
3. Intention 77
Recommendations 77
A. Listening to Family Members, Key Allies and/or Significant Others without a Release 77
B. Giving Resource Information to Family Members, Key Allies and/or Significant Others without a Release 78
Appendix L: Best Practices for Electronic Medical Records (EMRs) 79
Electronic Medical Records Guidelines 79
Developing a Policy / Planning for Implementation 80

Resources 81
Appendix M: Guidance on Benzodiazepine Prescribing Policies 82
Appendix N: Guidance on Peer Support Policies 85
Appendix O: Written Policy Requirements 85
1. Clinical Supervision Policy 86
2. Performance Evaluation Policy 86
3. Feedback from Participants, Families, Allies and Program Alumni Policy 86
4. Measuring the Effectiveness of Services Policy 86
5. Role and Impact of Peer Support Policy 86
6. Completion of High-Risk Behavioral Assessments Policy 87
7. Policy on the Prescribing of Benzodiazepines 87
8. Policy on the Use of Antipsychotic Medication in Children and Youth 87
and off-label) 87
Syndrome 88
Appendix Q: NIC 3.0 Fact Sheet 93
Self-Appraisal: (Appendix E) 93
Network Recognition Levels: (Appendix P) 93
DBHIDS Mandatory Outcome Measures: (Appendix G-V) 95

Letter from David T. Jones, Commissioner, DBHIDS

Dear Stakeholders:

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) plays an important role in improving and preserving the overall health status of all Philadelphians. The Practice Guidelines for Recovery and Resilience Oriented Treatment are intended to assist agencies with the implementation of services and supports that promote resilience, recovery, self-determination, and wellness in children, youth, adults, and families. To facilitate the next phase of our evolution, DBHIDS has created a five-year strategic framework, *Prioritizing to Address our Changing Environment (P.A.C.E)*. This road map will align the efforts of DBHIDS divisions and provider agencies to support the wellness of all Philadelphians. Additionally, it will dovetail with strategic plans developed by Health and Human Services (HHS), the Mayor's Office, and the State. P.A.C.E is designed to set priorities for delivering services and programs in a manner that aligns with our values and with our population health approach. DBHIDS continues to make changes to fiscal, policy, regulatory, and community contexts that 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. We will improve the quality of care, align with national health care reform, and make regulatory policies consistent with the principles and values promoted by the system. The existing credentialing process for facilities consists of staff file reviews, the review of policies and procedures as well as the review of clinical documentation; however, inclusion in the DBHIDS network will include a more comprehensive and balanced approach with the use of the Network Inclusion Criteria. The enclosed Network Inclusion Criteria (NIC) are the core capabilities that a provider agency will need to demonstrate to be recognized as part of the DBHIDS network regardless of the funding stream. These core capabilities will apply to all behavioral health and substance use services for children, youth, families, and adults, as well as across 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 the behavioral health field. The Network Inclusion Criteria's first phase of implementation began in 2013 and continues to evolve.

It is important to note that independent practitioners and group practices enrolled in the Pennsylvania Medicaid program and contracted with Community Behavioral Health (CBH) undergo a separate and distinct credentialing process managed by CBH. Equally important, however, is the alignment of this specific process with the underlying principles of our systems' transformation. To that end, all provider credentialing recommendations, regardless of provider type, are reviewed by the Credentialing Committee – a diverse panel of DBHIDS staff and network practitioners. As part of the ongoing implementation process, we will be encouraging feedback to help us advance the content in this document. We look forward to this collaborative process as we continue to move our system and Philadelphia forward.

Sincerely,

David T. Jones
Commissioner

SECTION I: OVERVIEW

Vision of Network Excellence

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is committed to ensuring individual well-being and healthy communities by developing and maintaining a strong network of care able to ensure access to services, effective and individualized holistic care, while simultaneously promoting community support and mobilization. The *Network Inclusion Criteria (NIC)* outlined within this document establishes a set of core capabilities that a provider will demonstrate to be approved for Network Recognition and maintained within 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 network. This document provides the essential details required to assist the provider community in understanding the standards, practices and scoring to be used in the re-credentialing process.

Philadelphia Behavioral Health Services Transformation

The *Network Inclusion Criteria* builds upon the ambitious transformation of provider concepts, practices and contexts by bringing innovations to the internal operations of DBHIDS and their relationship to agencies and the community-at-large. The Network Inclusion Criteria are derived from DBHIDS' groundbreaking transformation planning efforts. To date, they include:

1. *Population Health Transformation* approach builds on our history and expands our reach. Recognizing the interconnectedness of our wellbeing and the value of safeguarding health, we see an important role for DBHIDS in promoting wellness for our entire community. As a safety net agency with a population health focus, our responsibility is to serve our most vulnerable residents while promoting health and wellness for all Philadelphians

2. In 2011, the Department launched the *Performance Improvement Process (PIP), now titled 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.

3. The *Practice Guidelines for Recovery and Resilience-Oriented Treatment, referred to as the Practice Guidelines,* is a product of the partnership with agencies, people receiving services, 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.

4. *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.

The Network Improvement and Accountability Collaborative

The Network Improvement and Accountability Collaborative (NIAC) builds upon this foundation by establishing its fundamental role in creating and sustaining a high-quality network of care. NIAC, uses a comprehensive objective scoring tool, in conjunction with other internal reliability measures, to determine the degree to which providers are aligned with the principles outlined in 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 DBHIDS, providers, people receiving services and other stakeholders that are 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 the programs needed; and,
    - Identify providers who are demonstrating exceptional practice.

The Network Improvement and Accountability Collaborative serve as the oversight and monitoring mechanism in the execution of this aim. DBHIDS views the pursuit

of excellence as a shared effort amongst all stakeholders including external entities, provider agencies, DBHIDS, people seeking and receiving services as well as the community-at-large. This "collaborative" effort is critical in shaping future practices, is driven by the *Practice Guidelines* and is operationalized in the *Network Inclusion Criteria that*:

- Establishes the vision and desired direction for behavioral healthcare;
- Identifies 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.

The DBHIDS has advanced beyond what it traditionally considered "credentialing" to a much broader approach to *Practice Guideline* alignment as it continues to transform. Under the umbrella of the recovery/resilience-oriented system of care, DBHIDS has expanded our reach to a population health approach recognizing the interconnectedness of well-being and the values of safeguarding health for both the person and the whole community. This, in turn, has transformed the methods by which DBHIDS engages network accountability and performance improvement to create 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 into four practice domains augmented by an introduction section, entitled the *Foundations of Excellence in Service Delivery*. 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*. Additionally, there is an added *Single County Authority (SCA) Addendum* to meet the requirements of monitoring those providers who receive funding through Pennsylvania's Department of Drug and Alcohol Programs (DDAP). The sections to 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

Single County Authority (SCA) Addendum: Increased Practice Alignment for Substance Use Services

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. As part of the recredentialing preparation process, NIAC consults the OMHSAS website and reviews all applicable State licensure reports. We utilize this information for areas of alignment. Information about State licensure status is shared with the Credentialing Committee as well Prior to the NIAC review agencies will complete a *Self-Appraisal* based on the NIC. Given that the completion of this criteria-driven *Self Appraisal* functions as the first step in the review process, providers are afforded the opportunity and responsibility to fully partner in this process.

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 through 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-point scoring system. Each *Practice* within each

Standard will be scored using this scale. Each of the four *Domains* as well as the *Foundations of*
Excellence in Service Delivery detailed in Section III, includes the following structure, nomenclature and meaning:

- **Domains plus Organizational Focus (The Foundations of Excellence in Service Delivery)**:
  There are a total of four (4) D*omains* and one (1) *organizational focus* area (The *Foundations of*
  Excellence in Service Delivery). 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*.**

Tabulating the Level of Care Score (LOC Score)

1) Each NIC *practice* is scored on a three (3)-point scale, ranging from zero (0) to two (2).
   - **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.* 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 being reviewed.

TABLE I: Weightings for Domains and 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 four domains and the *Foundations of Excellence in Service Delivery*. 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 using 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

Network Recognition Level	Total Level of Care Score	Outcomes and Next Site Visit	Potential Network Incentives/Restrictions
Provisional Status	**Replaces 3month status**	**Does not meet minimal NIAC approval standards.** Mandatory CBH Quality Management Teaming required. Outcome to be determined by CBH Teaming.	Incentives and restrictions to be determined by funding source.
Warning Status	**≤59-69%**	Intermittently meets minimal NIAC approval standards**.** A **Six-month status** is awarded by CBH Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP. CBH Quality Management Department teaming to determine next steps along with an onsite Performance Improvement Plan (PIP) visit by NIAC with a mandatory technical assistance recommendation and referral from NIAC.	Incentives and restrictions to be determined by funding source.
Level 1: Basic Approval Status	**70- 79%**	Mets minimal NIAC approval standards. A **Oneyear status** is awarded by CBH Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP along with an onsite PIP visit by NIAC.	Incentives and restrictions to be determined by funding source.
Level 2: Sufficient Approval Status	**80-89%**	Satisfies NIAC approval standards. A **Two-year status** is awarded by the CBH Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP.	Incentives to be determined by funding source.

<u>Level 3:</u> **Excellent Approval Status**	**≥90%**	Fully meets network approval standards. <u>A</u> **<u>Three-year status</u>** is awarded by Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP.	Incentives to be determined by funding source.

SECTION III: THE NETWORK INCLUSION CRITERIA (NIC): COMPREHENSIVE DETAIL ON STANDARDS and PRACTICES

Section III details 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 emphasis 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*. More specifically, 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 promises 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 individual 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.

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, as well as the SCA Addendum.

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.

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, family/significant people and volunteers are staffed across the agency. ***(Information Sources: Staff Focus Group, Peer Discussion Group, Family Focus Group)***

Practice 2. An annual staff training course and development plan is in place for the agency and includes a calendar of annual training courses; 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 training implementation. ***(Information Sources: Staff Files)***

Practice 3. All clinical staff members are trained in trauma-informed assessments, interventions, and can therapeutically address the central importance of generational, lived and current traumatic experience. Additionally, there should be evidence that trauma informed training is made available to all staff members. ***(Information Sources: Staff Files)***

Practice 4. All clinical staff members receive training in the evidence-based/evidence supported approaches adopted by the agency to guide their implementation. ***(Information Sources: Staff Files)***

Practice 5. Strategies and implementation processes are in place to inform all staff of current information on behavioral, physical and community health related research and innovative practices. ***(Information Sources: Executive Level Interview)***

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 evidence-based/evidence-supported 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 and direct care staff receives recovery/resilience-oriented supervision regardless of employment status. 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. ***(Information Sources: Supervision Notes/Logs, Staff Focus Group, Written Policy, Living Review)***

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

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 and strengths are identified as part of the performance evaluation and are linked to the individual's ongoing learning plan. ***(Information Sources: Staff Files, Written Policy)***

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. The agency must identify emerging disparities regarding access, engagement, service quality and outcomes to ensure these areas are routinely monitored. Please see Appendix G-V for measures for suggestions. ***(Information Sources: Executive Level Interview, Written Policy)***

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 at a minimum, annually. The analysis informs the selection and implementation of program refinements based on program and participant needs. ***(Information Sources: Written Policy, Family Focus Group, Peer Discussion Group)***

Domain 1
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. 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: Tour/Observations)***

Practice 2. 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 engaging individuals in services. Outreach efforts are made (e.g., calls, text messages, etc.) and should be documented. ***(Information Sources: Living Review, Clinical Records, Family Focus Group, Peer Discussion Group)***

Practice 3. Physical plant accommodations are made to ensure that the needs and safety 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: Tour/Observations)***

Practice 4. The program assists individuals and families in pursuing and obtaining skills and resources to reduce barriers to services. Transportation resources are discussed, needs are identified, and supports are offered for individuals and family members. Additionally, information and assistance regarding access to dependent services is offered as needed. ***(Information Sources: Family Focus Group, Peer Discussion Group)***

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. 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, Mental Health First Aid, etc.). This includes outreach to school staff in the Philadelphia School system. ***(Information Sources: Executive Level Interview)***

Practice 2. Partnerships and learning exchanges are established with Child Protective Services (e.g. Community Umbrella Agencies (CUAs)), community police, fire, paramedics, and other emergency service responders to provide education and cross-system collaboration. ***(Information Sources: Executive Level Interview)***

Practice 3. The agency emphasizes the significance of population health through 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)***

Domain 2

Domain 2: Screening, Assessment, Service Planning and Delivery

Standard A: 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, Executive Level Interview, Living Review, Staff Focus Group)***

Practice 2. Empirically supported screening and strength-based assessment tools have been selected and implemented based on the needs and challenges of the individuals seeking services. The results of the selected tools should be interpreted and integrated into service delivery when necessary. ***(Information Sources: Clinical Records)***

Practice 3. All individuals are screened for trauma (including all forms of abuse); trauma-relevant assessments/tools are administered and interpreted if a traumatic experience was indicated. ***(Information Sources: Clinical Records)***

Practice 4. All individuals, regardless of age, are screened for evidence of bullying (physical, verbal, cyber, etc.) both as perpetrator and/or victim. ***(Information Sources: Clinical Records)***

Practice 5. Upon completion of the Comprehensive Bio-psychosocial Evaluation (CBE/CBR: completed by psychologist or psychiatrist) a clinical formulation is ideally 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 Sources: Clinical Records)***

Practice 6. For youth/adults seeking addiction services current versions of the *State Required Level of Care Assessment* is used in conjunction with a structured interview to determine the appropriate services.
A mechanism must be in place for making referrals when a Level of Care Assessment reveals that an agency is unable to accommodate the individual and family. (Refer to the Pennsylvania Department of
Drug and Alcohol Programs (DDAP) for the most up to date form. ***(Information Sources: Clinical Records)***

Domain 2: Screening, Assessment, Service Planning and Delivery Standard B: High Risk Behavioral Assessments (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 at intake for all individuals, regardless of risk, including the screening for suicidality and homicidality; bio-medical/physical concerns. For DDAP funded providers these screenings must include the emergent care questions which can be found within the DDAP Treatment Manual; additionally, the high-risk policy should clearly specify who completes the screenings ***(Information Sources: Clinical Records, Written Policy)***

Practice 2. If an individual screen positive for current (SI/HI within the last 24 hours) high-risk behavior, a more in-depth assessment of the specified behavior is

required to be completed and maintained in the clinical record. Agencies should have measures in place, to include possible referrals for an emergent evaluation for positive high-risk screens. 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; this should also include the development of a safety plan. Clinicians should be aware of triggers, including anniversaries and holidays. Bio-medical/physical concerns may require a medical evaluation and assessment of withdrawal-symptom severity. ***(Information Sources: Clinical Records)***

Practice 3. An incident reporting system must be in place for all high-risk behaviors addressed; including suicidal/homicidal attempts made, physical/mechanical/chemical restraints, elopements, suspected child abuse, Naloxone administration, and bio-medical/physical health concerns requiring urgent care, etc. Incident reporting must occur per guidelines at the state, city, and CBH level. Reference: Provider Bulletin #18-13 The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Community Behavioral Health (CBH) Significant Incident Reporting and Provider Bulletin # 07-5 Significant Incident Reporting for Crisis Response Centers/Emergency Assessment Centers.
(***Information Sources: Clinical Records)***

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 and based on the best available science (i.e. evidence-based/evidence-supported). 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,

appropriate evidence-based interventions 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 written in a strength-based manner and are informed by the person's unique culture (including faith, spirituality, sexual orientation, etc.). ***(Information Sources: Clinical Records, Living Review, Staff Focus Group, Family Focus Group, Peer Discussion Group)***

Practice 2. 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 occur 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)***

Practice 3. 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, evidence-based interventions, etc.) and all corresponding dates. Updated plans include the documentation of progress. ***(Information Sources: Living Review, Clinical Records)***

Practice 4. 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: Staff Focus Group, Peer Discussion Group, Living Review, Clinical Records)***

Practice 5. A safety/crisis plan is in place for all children, youth, adults and families experiencing high-risk behaviors and/or at risk for ongoing traumatization. A detailed safety/crisis plan captures the following components: triggers, early warning signs, supports (names/phone numbers), what the individual can do to de-escalate on their own, and specifics of who they can call or go to if additional support is needed. This should be routinely assessed throughout service delivery. ***(Information Sources: Clinical Records)***

Practice 6. Methadone Maintenance Treatment (MMT) Centers are defined as any program approved by all relevant regulatory authorities to prescribe and/or dispense methadone for the treatment of addiction. MMT 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 cooccurring psychiatric conditions. Site visits may include evaluation of adherence to counseling requirements, issues around potential drug misuse, urine drug screening and follow up. Reference: CBH Implementing the Philadelphia Mayor's Opioid Taskforce Recommendations: Background Re: Bulletins 18-06—18-08. ***(Information Sources: Policy, Clinical Records)***

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. Comprehensive medication histories and current medications are documented (e.g. medication logs) including the use of non-psychotropic, as needed (PRN), and over-the-counter (OTC) medications. Allergies involving medication are noted in detail. Chronic conditions are highlighted (i.e. Diabetes, HIV, etc.). ***(Information Sources: Clinical Records)***

Practice 2. Documentation of medication monitoring shall include all items indicated in Appendix G-III. ***(Information Sources: Living Review, Clinical Records)***

Practice 3. Outreach for missed medication appointments must occur and be documented. ***(Information Sources: Clinical Records, Living Review)***

Practice 4. There is compliance with Provider Bulletin (#18-12) DBHIDS-CBH Clinical Guidelines for the Prescribing and Monitoring of Antipsychotic Medications for Youth concerning prescribing and treatment practices to include; psychiatric evaluation, medication side effect monitoring (e.g. involuntary movements, adverse metabolic and cardiac effects), behavioral health services, and consent and assent (CBH Bulletin # 10-03). ***(Information Sources: Written Policy, Clinical Records, Self-Appraisal)***

- CBH Bulletin (#10-03) regarding informed consent for the use of off-label medications for children and adolescents to include the use of educational materials for parents/legal guardians 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.

Practice 5. 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: Written Policy, Clinical Records)***

Practice 6. There is a Benzodiazepine Prescribing Policy in place regarding the use and prescribing practice of benzodiazepines. Each provider who prescribes medications is required to have such a policy in place, incorporating the guidelines found within Appendix M, and must include how monitoring for fidelity to the policy will occur. Policies should also specify how the requirements of the Pennsylvania Prescription Drug Monitoring Program (PDMP) will be adhered to by the prescribers. ***(Information Sources: Written Policy, Clinical Records)***

Domain 3

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. Staff and peers' partner with individuals and their families/support persons 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 and Friends of Lesbians and Gays (PFLAG), Housing, 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: Living Review, Clinical Records, Executive Level Interview, Staff Focus Group, Family Focus Group, Peer Discussion Group)***

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

Domain 4

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. Peer culture is continuously evaluated to determine its contribution to the overall quality of service delivery. Peer support staff, peer volunteers, people

receiving services and their families/support persons are involved in this ongoing task. ***(Information Sources: Executive Level Interview, Staff Focus Group, Written Policy, Self-Appraisal)***

Practice 2. 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. 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: Staff Focus Group, Family Focus Group, Peer Discussion Group)***

Practice 3. The program demonstrates the development of family-to-family peer support through engagement with families (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: Family Focus Group; Peer Discussion Group; Staff Focus Group)***

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 Review, Staff Focus Group)***

Domain 4: Community Connection and Mobilization

Standard B: Strengthening Community Inclusion and Mobilization

Objective: Agencies acknowledge and make full use of the community's role AND potential 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,

such as employment, education, volunteer opportunities, spiritual and recreational opportunities in the community. ***(Information Sources: Staff Focus Group, Family Focus Group, Peer Discussion Group)***

Practice 2. Providers have established effective partnerships within the community to serve the continuing care and needs of people receiving services. Relationships are created with local schools, places of worship and other community organizations (e.g., faith-based groups, food shelters, housing, educational resources) in support of this effort. ***(Information Sources: MOU Review, Executive Level Interview)***

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. The agency has reached out to primary care physicians (PCPs) to share/provide 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: Executive Level Interview)***

Practice 2. Providers assist participants in accessing critical preventative and diagnostic healthcare services through referrals or coordination with community healthcare supports, to include assessing and screening for conditions such as tuberculosis. ***(Information Sources: Living Review, Clinical Records)***

Practice 3. Bi-directional referral agreements are established with physical health providers (to include pediatricians). 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: MOU Review)

Practice 4. There is compliance with Provider Bulletin #16-04 regarding the On-site Maintenance, Administration and Prescription of Naloxone. Each provider must adopt policies and procedures ensuring that there is staff equipped (via training) to identify persons in need of and to promptly administer Naloxone as indicated. Additionally, such policies and procedures should ensure the acquisition, storage, monitoring, administration, and safe disposal of used and expired Naloxone. ***(Information Sources: Written Policy, Staff Files, Tour/Observations)***

Practice 5. The provider screens and assesses individuals for tobacco use; additionally, individuals are offered tobacco use recovery treatment and/or referred to external programs; such as those related to tobacco support. Further, there is evidence of no-smoking signs throughout the facility and there is a Tobacco-free policy in place to encourage a tobacco free environment for those receiving services, visitors and employees. ***(Information Sources: Written Policy, Tour/Observations, Clinical Records)***

Single County Authority (SCA) Addendum

Single County Authority (SCA) Addendum

Standard A: Increased Practice Alignment for Substance Use Services

Objective: All provider agencies who receive funding through Pennsylvania's Department of Drug and Alcohol Programs (DDAP) are consistently following the procedures and protocols outlined within both the DDAP Treatment and Operations Manuals. The SCA ensures adherence to the procedures and protocols stipulated.

Practice 1. The provider ensures that sexual harassment will not be tolerated, and employees are aware of the agency's policies and procedures in relation to addressing instances of sexual harassment. ***(Information Sources: Written Policy Review)***

Practice 2. The provider has policies and procedures in place to ensure that there are interim services available for those individuals who are Pregnant Women and those who are Injection Drug Users. This policy ensures that the identified individuals are offered interim services if they are not admitted into treatment

within 14 days after completion of the level of care assessment. The policies and procedures in place are consistently being adhered to by staff. ***(Information Sources: Written Policy Review, Clinical Records)***

Practice 3. There is a policy in place regarding the SCA's grievance and appeal process. Individuals receiving services are made aware of this process in the event they want to file a grievance and/or appeal regarding substance use treatment services. There is evidence that the individual acknowledged receipt of this information via a signed SCA grievance and appeal form that is retained in the individual's chart. ***(Information Sources: Written Policy, Clinical Records)***

Practice 4. If the SCA limits assessment or admission to treatment, individuals are made aware and a signed SCA limitation form is retained in the individual's chart. Additionally, if an individual is receiving Medication Assisted Treatment, there is a signed notification of any limitations, including the requirement to participate in treatment; or to have successfully completed a treatment regimen. ***(Information Source:***
Clinical Records)

Practice 5. A liability determination is completed for everyone receiving services and is retained in the individual's chart. Liability is determined prior to a referral to or admission into applicable treatment services. A standard liability form is used in its unaltered state. ***(Information Source: Clinical Records)***

Practice 6. Providers ensures that there is a confidentiality policy in place that addresses the following areas; release of individual-identifying information, storage and security of clinical records, computer security of clinical records, staff access to records, confidentiality training for all applicable staff, disciplinary protocols for staff violating confidentiality regulations, revocation of consent, and notification that re-disclosure is prohibited without proper consent. Providers also ensure that the policy is consistently implemented and appropriately completed consent forms are retained in the individual's clinical record. ***(Information Sources: Written Policy, Staff Files, Clinical Records)***

Practice 7. Providers have a policy in place that clearly specifies those populations who are given priority; which should be in the following order, 1. Pregnant Injection Drug Users; 2. Pregnant Substance Users; 3. Injection Drug Users; 4. Overdose Survivors; and 5. Veterans. The policy must include language stating that all individuals identified as part of the priority population are offered admission to the recommended level of care immediately. ***(Information Source: Written Policy)***

Practice 8. Providers ensure that the SCA is notified within seven days upon reaching 90% capacity for admission of individuals who are Injection Drug Users (IDU). ***(Information Source: Written Policy)***

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. ***An Integrated Recovery-oriented Model (IRM) for mental health services: evolution and challenges - PMC***
2. ***Approaches to Recovery Oriented Systems of Care at the State and Local Levels: Three Case Studies***
3. ***ASAM Placement Summary Sheet***
4. ***DBHIDS Peer Support Toolkit***
5. ***Evidence-Based Practice and Innovation Center (EPIC)***
6. ***Family Resource Network (FRN) Family Inclusion Standards***
7. ***Implementing the Philadelphia Mayor's Opioid Taskforce Recommendations: Background Re: Bulletins 18-06—18-08***
8. ***Opioid Prescribing Guidelines***
9. ***Pennsylvania Prescription Drug Monitoring Program (PDMP)***
10. ***Peer Culture and Community Inclusion Unit (PCCIU)***
11. ***Practice Guidelines for Recovery and Resilience-Oriented Treatment***
12. ***Prioritizing to Address Our Changing Environment (P.A.C.E.): A strategic framework to move us forward. The Philadelphia Department of Behavioral Health and Intellectual disAbility Services Strategic Framework***
13. ***Provider Bulletin # 07-5 Significant Incident Reporting for Crisis Response Centers/ Emergency Assessment Centers***
14. ***Policy Regarding the Screening for and Treatment of the Components of Metabolic Syndrome Bulletin #07-07***
15. ***Provider Bulletin #10-03-Use of Psychotropic Medications in Children and Adolescents (FDA Approved and Off-Label)***

16. ***Provider Bulletin #17-10-On-site Maintenance, Administration and Prescription of NALOXON: Extended Deadlines and Associated Fines***
17. ***Provider Bulletin # 18-13 The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Community Behavioral Health (CBH) Significant Incident Reporting***

a. ***Philadelphia Department of Behavioral Health Significant Incident Reporting Form***

18. ***Provider Manual***
19. ***Recovery Management and Recovery Oriented Systems of Care***
20. ***SAMHSA Evidence-Based Practices Kits***
21. ***SAMHSA-HRSA Center for Integrated Health Solutions***
22. ***Tools for Transformation: Community Integration***
23. ***Tools for Transformation: Extended Recovery Supports***
24. ***Tools for Transformation: Holistic Care***
25. ***Person Centered Planning***
26. ***Utilization Management Guide***
27. White, W., Schwartz, J. and 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.

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
Abuse the System	Resourceful - self advocate

Appendix B continued: Glossary of Terminology

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 EvidenceBased/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) – This consist of a practice that has been demonstrated to be effective through an accumulated body of well-designed research studies conducted by more than one research team in diverse settings and populations.

Evidence-Supported Practice(s) - A practice that has demonstrated positive outcomes in a limited number of research studies or in studies that use quasi-experimental designs. This could also include a practice that has a strong body of research support but is being delivered to different population or in a different setting.

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 other 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.

Promising Practice(s) - A practice that has demonstrated some positive outcomes through evaluation or research, but those studies are limited in their research methodology and the practice has not yet been evaluated through more rigorous or generalizable methods.

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 and 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 TIP – Transitions, Integration, and Partnerships)
ACT NOW	Advocacy and 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
BH	Behavioral Health
BHS	Behavioral Health System
BHRS	Behavioral Health Rehabilitation Services
BHSI	Behavioral Health Special Initiatives
BHTEN	Behavioral Health Training and 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
CAP	Corrective Action Plan
CASSP	Children and Adolescent Services Systems Program
CBE	Comprehensive Bio-psychosocial Evaluation
CBH	Community Behavioral Health
CBR	Comprehensive Bio-psychosocial Re-evaluation
CBT	Cognitive Behavioral Therapy
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
CRR-m	Moderate Care Community Residential Rehabilitation
CRR-x	Maximum Care Community Residential Rehabilitation
CRS	Certified Recovery Specialist
CST	Consumer Satisfaction Team, Inc.
CY	Calendar Year (1/1/XX – 12/31/XX)
CYS	Children and Youth Services
DandA	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	Diagnostic and Statistical Manual of Mental Disorders
DX	Diagnosis
EAC	Extended Acute Care
EBP	Evidence Based Practice
EEC	Emergency Evaluation Center
EHR	Electronic Health Record
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 for Service
FIR	Forensic Intensive Recovery
FY	Fiscal Year
HFW	High Fidelity Wrap
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
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Ally/Asexual
LOC	Level of Care
LTSR	Long Term Structured Residence
MA	Medical Assistance
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
MPRS	Mobile Psychiatric Rehabilitation Services
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

OBH	Office of Behavioral Health
OESS	Office of Emergency Shelter Services (see OHS)
OMH	Office of Mental Health
OHS	Office of Homeless Services (replaces OESS and OSH)
OP	Outpatient
OSH	Office of Supportive Housing (see OHS)
OTC	Over the Counter Mediation
OVR	Office of Vocational Rehabilitation
PCBH	Personal Care Boarding Home
PCCI	DBHIDS Peer Culture and Community Inclusion Unit
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 and 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”)
PRS	Psychiatric Rehabilitation Services
PTSD	Post Traumatic Stress Disorder
QI	Quality Improvement
QIP	Quality Improvement Plan
RC	Resource Coordinator
RINT	Residential inpatient Non-Hospital Treatment
RITA	Residential Intensive Treatment Alternatives
RT	Residential Transformation

RTF Residential Treatment Facility
RTFA Residential Treatment Facility *for* Adults
SAMHSA Substance Abuse and 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

SUD Substance Use Disorder
TANF Temporary Assistance to Needy Families
TC Treatment Court
TCM Targeted Case Management
TEP Transitional Employment Program
TIP Transition, Integration, and Partnerships (formerly AAS)
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.

(AFG) Adolescent Focus Group - CPS led discussion group facilitated by DBHIDS.

(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*.

(FFG) Family-Inclusion Focus Group - A focus group facilitated by NIAC team members with primary caregivers or supporters of individuals receiving services.

(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 concludes this process to provide collaborative feedback, specifically focusing on strengths. The Living Review may be modified at times, particularly for different LOCs.

(MOU) Memoranda of Understanding Review – NIAC team members will review any and all current Memoranda of Understanding (MOUs) submitted by providers to show evidence of established relationships, partnerships and agreements with external entities within the community.

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

(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 training courses; 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 (NIC): Agency Self-Appraisal

Purpose: Partnership and transparency are two of the values underlying the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) system transformation. This Self-Appraisal represents a partnership in action, as it offers an opportunity for organizations to provide relevant information regarding the implementation and ongoing development of the Practice Guidelines within the

organization. *Please note that programs may take different approaches to align with the Practice Guidelines.*

Instructions: The Agency Self-Appraisal is designed to guide organizations through a process of examining agency policies and practices to determine alignment 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 members as well as people receiving services within the organization. The Self-Appraisal will be one of several sources of information that Network Improvement and Accountability Collaborative (NIAC) will use to provide a comprehensive view of the agency.

The Network Inclusion Criteria should be referred to when completing the Self-Appraisal. The NIC can be located at the DBHIDS website and the CBH website. In addition, if the agency has had prior NIAC site reviews, please highlight any changes and improvements made since the most recent site review.

Please submit one Self-Appraisal for the entire agency and limit the response to no more than five pages in length.

Please submit a blank template of all Assessment Forms utilized within the agency. These should be submitted with the agency's Pre-Visit Documents.

Foundations of Excellence in Service Delivery

Discuss how the agency ensures excellence in service delivery with all staff members, and how supervision is conducted to align with the recovery and resilience transformation. Also describe how the agency determines the quality of care that is being provided and how outcomes are measured.

- *Has your agency been involved with any DBHIDS initiatives (NIATx, Behavioral Health Screenings, Etc.)? If so, please indicate which initiative, the outcome and the dates.*

- *How many individuals do you serve in a calendar year, and of that number served how many are insured by CBH and/or BHSI?*
- *When individuals with forensic experiences present to the agency programs, what methods are utilized to support these individuals?*

Domain 1: Assertive Outreach and Initial Engagement

Discuss how the agency facilitates early intervention, promotes easy access to services, and responsive engagement to the community.

- *Does your agency provide language access for those in need? If so, what specific languages or dialects are within the demographic you serve?*
  - ***a.*** *In addition, please explain the agency's policy and procedures for providing language access services (e.g. translation services, use of staff that speaks different languages, etc.).*
- *How does your agency accommodate populations that are deaf and/or hard of hearing, or individuals that are blind?*

Domain 2: Screening, Assessment, Service Planning and Delivery

Discuss how the agency assures that individuals are screened for emergent care needs and treated, if needed, how the agency ensures that strengths-based assessments and evaluations are completed, how the agency ensures that recovery and resilience plans are person-centered and are the focus of service delivery. Also, discuss how the agency ensures that medications practices are safe and effective.

- *How does the agency ensure internal compliance is monitored and maintained for all policies required by DBHIDS-CBH?*
- *Submit incident reporting rates on all the following high-risk behaviors including:*
  - *Suicidal/homicidal attempts*
  - *Physical/mechanical/chemical restraints*
  - *Elopements*
  - *Naloxone administration*

- *Bio-medical/physical health concerns requiring urgent care, etc.*

Domain 3: Continuing Support and Early Re-Intervention

Discuss how the agency ensures that continuing support planning occurs throughout the service experience and how the agency provides easy access for re-engagement.

Domain 4: Community Connection and Mobilization

Discuss how the agency fosters peer culture to include peer support and leadership. Also, discuss how the agency creates partnerships within the community, and any reciprocal referral agreements that were developed because of these partnerships. How are physical and behavioral healthcare services integrated into the services the agency provides?

- *For Drug-Free Substance Use Treatment Providers: Describe any formal referral agreements with Medication Assisted Treatment (MAT) providers.*

Appendix F: Practice Guideline Framework

The Framework

<table>
<tr><td>7 Goals:</td><td colspan="4">4 Domains:</td></tr>
<tr><td rowspan="3">A. Provide Integrated Services.
B. Create an atmosphere that promotes strength, recovery and resilience.
C. Develop inclusive, collaborative service teams and processes.
D. Provide services, training and supervision that promote recovery and resilience.
E. Provide individualized services to identify and address barriers.
F. Achieve successful outcomes through empirically.
G. supported approaches.
H. Promote recovery and resilience</td><td>Domain 1: Assertive outreach and initial engagement.</td><td>Domain 2: Screening, assessment, service planning and delivery,</td><td>Domain 3: Continuing support and early reintervention.</td><td>Domain 4: Community connection and mobilization.</td></tr>
<tr><td colspan="4">10 Core Values:
In each domain, all 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:</td></tr>
<tr><td colspan="2">1. Strength-based approaches that promote hope.
2. Community inclusion, partnership and collaboration.
3. Person- and family-directed approaches
4. Family inclusion and leadership.
5. Peer culture, support and leadership.</td><td colspan="2">6. Person-first (culturally competent) approaches.
7. Trauma-informed approaches.
8. Holistic approaches toward care.
9. Care for the needs and safety of children and adolescents.
10. Partnership and transparency.</td></tr>
</table>

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 A

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
- Urgent Screenings/High Risk Behavioral Assessments (to include the assessment of any immediate/current onset of suicidality, homicidally, and bio-medical/physical concerns)
- 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
- Comprehensive Assessment of Gambling (history and/or present)
- Past/Present history of aggression/suicidality/abuse, when identified
- Detailed summary of the person's support system
- DSM 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):

- Presenting Challenge
- Urgent Screenings/High Risk Behavioral Assessments (to include the assessment of any immediate/current onset of suicidality, homicidally, and bio-medical/physical concerns)
- 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. 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
- 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):

- Clinical Justification for CBR
- Demographic Information:
- Urgent Screenings/High Risk Behavioral Assessments (to include the assessment of any immediate/current onset of suicidality, homicidally, and bio-medical/physical concerns)
- 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
- Recommendations for Interventions

Recommended Prompts to Ascertain 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 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.*

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
- Group Size
- 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 refer to the Provider Manual for additional details.

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 and dosage of medication including all over-the-counter medications, home remedies and herbal supplements – as dosages change, the note shall indicate the rationale for the change.
- Documentation regarding medication reconciliation shall include medications prescribed to an individual by all internal and external entities to the agency, to include medications prescribed by the individual's PCP and other specialties.
- The date of each medication order.
- The means of administration.
- The medication schedules.
- The reason for the medication, to include the individual's diagnosis.
- The individual's response to medication.
- The adverse effects of medication.
- Written consent of the individual and/or legal guardian.
- Adherence to the agency's off-label medication prescribing policy (in accordance with CBH Bulletin #10-03).

- Adherence to the agency's policy regarding the Screening for and Treatment of the Components of Metabolic Syndrome (in accordance with CBH Bulletin #07-07).
- Adherence to the agency's policy regarding the Clinical Guidelines for the Prescribing and Monitoring of Antipsychotic Medication for Youth (in accordance with DBHIDS-CBH Bulletin # 18 to 12).
- 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.
- Overall documentation includes areas of progress, continuing or new challenges for the person, collaboration with the therapist/team, detailed rationale of medication changes, and possible referrals, etc.

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 Management Guide.

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.
- DSM Diagnosis (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. (e.g. referral of families to family support groups).

Please note: CRCs and Substance Use Treatment providers should ensure adherence to CBH Provider Bulletin 18-07.

Appendix G- V: DBHIDS Mandatory Outcome Measures

Major Headings and Suggested Items to Measure

The strategic framework adopted by DBHIDS in 2018, P.A.C.E., (Prioritizing To Address Our Changing Environment) sets forth the prioritization of outcome measures as one of its core values. Towards that aim, NIAC is recommending that all providers collect, track, report, and utilize results to enhance quality of care for all individuals served. The strategic planning process focuses on the five-areas listed below.

It is recommended that providers select at least one outcome from each of the categories listed below. NIAC will collect the reported data and review its implementation as part of the re-credentialing process.

PREVENTION and EARLY INTERVENTION	TREATMENT and SERVICES	HEALTH ECONOMICS	INFRASTRUCTURE and INTELLIGENCE	INNOVATION
4 Focus Areas	**5 Focus Areas**	**3 Focus Areas**	**2 Focus Areas**	**2 Focus Areas**
1. Trauma-Informed Care. 2. Community Inclusion/Population Health. 3. Accessibility and Availability. 4. Criminal Justice System.	1. Increase Services to Vulnerable Populations (consider individuals impacted by opioid crisis, returning citizens, and trauma survivors). 2. Trauma-Informed Care. 3. Strengthening Workforce Efforts. 4. Peer Leadership Opportunities. 5. Value Based Services.	1. Referrals to External Professional Community-Based Resources. 2. Employee Wellness and Productivity. 3. Value Based Services.	1. Adherence to Practice Guidelines through values, goals, and activities. 2. Participant feedback include adherence to Family Resource Network (FRN) 2018. 3. Best Practice Standards.	1. Create staff wellness programs to improve moral and increase staff retention rates. 2. Improve internal systems to enhance tracking of service delivery.

Appendix H: Training courses

Staff need continual training courses 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 training courses indicated in the Community Behavioral Health (CBH) Credentialing Handbook for Network Providers and CBH Bulletins, as part of the NIAC review process additional training courses will need to occur for staff, as identified within this Appendix.*

DBHIDS Training Learning Hub: Provider Enrollment

Additional Training Resources:

Behavioral Health Training & Education Network

Mental Health Partnerships: CPS Training

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 tasks are the deepening of their application in practice. It is recommended that ongoing training and supervision reflect this system's need. Course offered; Introduction to Practice Guidelines. BHTEN 520 N. Delaware Avenue. 215-923-2116. bhten.com.

Evidence-based, evidence-informed and agency adopted best practice

Supervisors must receive specialized training in the evidence-based practices (EBPs) adopted by the agency 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. Contact EPIC to register for on-line course; Introduction to Evidence Based Practices, dbhids.org/epic.

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) Contact Trauma Unit, dbhids.org/trauma.

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. Course offered; Mental Health First Aid.

Family Resource Network Family Inclusion 2018 Best Practice Standards
These standards provide direction to agencies regarding the inclusion of family and other significant people within the recovery/resilience process of their loved ones. All staff must be trained on Family Inclusion (FI) practices which should align with the Family Resource Network Best Practice Standards, detailed within Appendix J of this document. Family Inclusion Best Practice Standards, 520 Delaware Avenue, Suite 200.

Peer Support/Peer Culture Training

Peer culture, support and leadership is an essential core value underlying the transformation of the behavioral health system to a recovery-oriented system of care (ROSC). All providers should incorporate this core value throughout their organizations and services delivered. Providers need to ensure that all direct service personnel receive training to learn the ROSC values, what defines peer culture, the role of peer staff, and best practices that are low-cost to no-cost for organizations to implement today.

DBHIDS policies and best practices for services to LGBTQIA communities
All providers should follow the guidelines set forth within the *Office of Mental Health and Substance Abuse (OMHSAS) Bulletins #11-01 and #11-02*. In addition, it is required that regular training and skill building opportunities, conducted by specialists who work with people in LGBTQIA+ communities, be a part of the staff development program for all agencies. Training courses should address meeting the clinical needs of LGBQ, as well as transgender, gender non-conforming and individuals who are Intersex. All staff members must complete basic LGBTQIA+ cultural awareness training within one year of hire. This may be incorporated into another cultural awareness training, as long as two and a half (2.5) hours are devoted to the LGBTQI topic content put forth in the OMHSAS *bulletins* and within *DBHIDS Practice Guidelines*. BHTEN 520 N. Delaware Avenue. 215-923-2116.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
All providers must offer training on HIPAA at least annually to ensure employees remain up to date on any potential changes to the law and its potential impact on the delivery of services. Training courses should thoroughly address all HIPAA related rules as well as how those rules correlate to the delivery of services at a

given provider agency. Ultimately the training courses should serve to enhance confidentiality practices and ensure privacy of health-related information for those individuals receiving services.

Mandated Reporting

All providers should ensure that all direct service personnel receive training on the topic of *Mandated Reporting*. The training should thoroughly cover the responsibilities of a Mandated Reporter, who are Mandated Reporters, the process of reporting suspected child abuse, etc. The training should ensure that direct service professionals employed by the provider agency are equipped with the necessary information to file a report in the event child abuse and/or neglect is suspected. PA Family Support Alliance, on-site Mandated Reporters Training and on-line training, 800-448-4906.

Additional training courses required for programs funded under Pennsylvania's Department of Drug and Alcohol Programs (DDAP): BHTEN, 520 N. Delaware Avenue, 215-923-2116.

All DDAP funded providers must follow the requirements set forth within Pennsylvania's DDAP Treatment Manual. All people providing adult and/or adolescent treatment, and their supervisor, must complete the following training courses.

- DDAP approved training on the most up to date level of care assessment, e.g. ASAM.
- DDAP approved or Pennsylvania Certification Board (PCB) approved Confidentiality.
- DDAP approved Practical Applications of Confidentiality Laws and Regulations.
- Screening and Assessment.
- Addictions 10.

Recommended Documentation for Training

1. An agency-wide annual training plan should be in place, and should include the following:

- An annual assessment of agency training needs and 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 training courses, 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.

2. Documentation of provider in-service training curricula

The provider should maintain documentation of all in-service training courses offered and conducted (mandatory and ongoing). This documentation should fully reflect the *content* and *attendance* of the training courses.

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 course 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 training courses.

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 training courses as well as training courses that the employee identify as a need;
    - The employee and the supervisor should sign the plan.
- Documentation of completed training courses 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 training courses. 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 employee's file. This should include the training certificate.

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 people 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 refer to **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.
- There should also be some form of regular supervision and/or oversight for contracted staff. This process should be clearly specified by the provider.
- 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 children 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) Certified Family Inclusion Standards 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.

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 supervise 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 2018 Best Practice Standards Involving Participant-Identified "Family" in Behavioral Treatment and Recovery Programs

The FRN Family Involvement (FI) Standards are part of the Philadelphia Department of Behavioral Health/ Intellectual disAbility Services Practice Guidelines.

Statement of Purpose:
Family Inclusion certification is designed to help providers implement best practices in family inclusion.

Definitions:
The term "participant" as used here is meant to apply to those who participate in and receive behavioral health services, also known as *consumers* or *persons in recovery*.
The term "family" includes everyone (other than treatment staff) who may be important to participants' recovery and treatment: family members, friends, relatives, roommates, spouses/partners, clergy, etc.
Identifying important family to involve in participants' recovery is a collaborative process between participants and staff members. A release of information from the participant

is always necessary to allow staff to contact family, except in cases of threat of injury or death.

Summary of Best Practice Standards: To conform to FRN FI Best Practice Standards, providers must, at a minimum, adopt the following as formal policies and procedures, and formally monitor participant records for documentation of the ongoing use of these practices.

1. Obtain a Release of Information

- During the initial intake or admission interview, all participants should be asked to identify at least one person who may be important to their treatment and recovery, and then be asked to sign a release of information
- When there is no release of information signed, or there is no family identified, documentation should show 1. the attempt to identify a family member or support 2. the reason this task could not be completed.
- Any concerns the participant has regarding family should be documented.
- If the individual is unwilling or unable to sign a release at the start of services, ongoing attempts should be made. A refusal for family contact at the start of services may not always be a refusal once the individual becomes more comfortable with the staff and treatment setting.

2. Contact the Family

Documentation should reflect the first contact with family and staff attempts to:

- 1. Introduce the staff or team 2. Their contact information 3. Discussion of key issues.
- Acquire relevant information about the participant from the family.
- Discuss the benefits and barriers to family inclusion in treatment.
- 1. Ask the family about any questions or concerns they may have 2. And how these questions and concerns were addressed.
- Provided guidance, resources, and/or referrals for family in supporting the participant.

3. Offer Ongoing Support, Guidance, and Resources to all Families

- A policy or guideline should be in place that disseminates program information to all families.
- Information should be available onsite for distribution that contains program details; and describes how families are included in the program.
- There should be a process in place for referring family members to receive assistance or support for matters that may not be directly related to the participants' services.
- There should be a process developed to educate all staff members that, even without a signed release, that resources and program information are available to anyone who asks for it.

4. Engage the Participant in Conversation Around Family

Staff should help the participants to think through the benefits and barriers to family inclusion and how this impacts their recovery.

Documentation should reflect:

- Both formal and informal discussion around family.
- When family is discussed in individual, group, or general setting.

5. Engage Family in Recovery Planning

Clinical documentation should reflect:

- That the participant was asked to allow family to be included in the recovery planning process, and whether the participant agrees
- That the family was invited to participate in the recovery planning process
- If the family is not included, documentation should reflect why.
- It should be documented when accommodations are needed, and how it was addressed to allow family to participate.

6. Provide all Staff Regular Training and Supervision Around Family Inclusion

Agencies or provider programs should have the following in place:

- A policy that provides general family inclusion training to all program staff.
- A policy that provides targeted training around family inclusions for supervisors and those working directly with families.
- Specific guidance for supervisors around family inclusion practices.

7. Formally Monitor Ongoing Staff Family Inclusion Practices

Agencies or provider programs should have the following:

•A policy or process to complete a formal chart review to internally monitor family inclusion practices. The result of this review will be submitted and reviewed by FRN annually.

•A policy or process that utilizes the outcomes of the monitoring process to inform family inclusion practices within the program or agency. (*Reference:* Appendix G-V: DBHIDS Mandatory Outcome Measures)

8. Collect Regular Feedback from Family

Agencies or provider programs should have processes in place for the following:

- To gather regular feedback from family members about their experience with the program and or agency.
- To gather regular feedback from family members about their experience with the program and or agency.
- To report this feedback to the Family Resource Network (FRN).

9. Recruit Family to Serve on Boards, Committees, or Other Advocacy Groups

Agencies or provider programs should have processes in place for the following:

- To create opportunities to allow families to participate in advocacy or program improvements.
- To allow family representatives to serve on the agency boards or other committees or advisory groups.
- To make families aware of these opportunities within the program or agency.

Appendix K: City of Philadelphia Department of Behavioral Health and 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 must 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 and 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 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 recommended 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 beginning 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 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 deemed satisfactory 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 existing originally in paper form are scanned to make an electronic record, the original paper record shall be available for (one licensing cycle).
- Electronic databases are reasonably secure and accessible by password, etc.

- Electronic signature must be attached to the applicable document; it is not satisfactory 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 checkboxes 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 training and ongoing support developed accordingly.

Resources

U.S. Department of Health and 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*

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.

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*

Office of the National Coordinator for Health Information Technology, Federal Health Information Technology Strategic Plan

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

Appendix M: Guidance on Benzodiazepine Prescribing Policies

All providers who have the ability to prescribe medications need to have policies in place that will assure adherence to the recent benzodiazepine prescribing guidelines within their programs. These will necessarily vary due to differences in program structure, patient population and other factors.

In addition to the content-specific requirements, each area of the policy must specify a mechanism for internal assurance of implementation (via chart reviews, etc.).

Additionally, all providers must specify how the requirements of the Pennsylvania Prescription Drug Monitoring Program (PDMP) will be adhered to by their prescribers.

1. Regarding Standard 1 (Benzodiazepines should not be initiated as monotherapy for the treatment of anxiety disorders), providers should submit policies that assure that treatment planning for anxiety incorporates non-medication strategies and non-benzodiazepine medications as "Firstline" for the treatment of anxiety. Policy must also require documentation of medical decision making to fully explain when, for reasons of appropriately individualizing treatment, benzodiazepine monotherapy is to be undertaken.

2. Regarding Standard 2 (Benzodiazepines should not be used for the treatment of insomnia without appropriate evaluation, and should not be used chronically), providers should submit policies that assure that treatment planning for insomnia incorporates appropriate screening and evaluation for underlying causes of insomnia and co-occurring sleep disorders. Policy must also require documentation of medical decision-making to fully explain when, for reasons of appropriately individualizing treatment, benzodiazepine use for insomnia continues beyond 4 weeks.

3. Regarding Standard 3 (Benzodiazepines should not be prescribed to patients with substance use disorders), providers should submit policies that assure appropriate screening for substance use disorders in their patient population. Policies must specify how SUD will be evaluated, including collateral information, UDS or other supplement to patient self-report. Policies must specify documentation requirements and necessary measures to minimize the risk of compromising recovery when, for reasons of individualized treatment, controlled substances are to be prescribed to patients with history of substance use disorders.

4. Regarding Standard 4 (Benzodiazepines should not be prescribed to patients enrolled in medication-assisted treatment (MAT) for opioid use disorders, or who are prescribed chronic opioid medications for pain), providers must provide a policy that assures that benzodiazepines are not prescribed to patients who are also receiving prescription opioids (see PDMP requirements above), or who are receiving medication-assisted treatment

(MAT) with opioid agonists. This policy must include measures to screen for opioids and MAT, such as via the PDMP, urine drug screening or other collateral sources. In cases where benzodiazepines are to be co-prescribed with opioids/MAT, the policy must assure coordination with the opioid prescriber, as well as appropriately documented rationale for such a prescription to continue. The policy
must also provide procedures for tapering of benzodiazepines when opioids/MAT are begun or discovered once benzodiazepines have already been initiated.

It is important in drafting such policies to specify:

- To which individuals/members do the policy apply,
- Which staff are responsible for each procedure,
- How implementation will be assured.

For example, *"Patients with SUD will not be prescribed benzodiazepines"* is not an acceptable policy element. Below is an example of an acceptable policy element.

"All individuals presenting for a comprehensive biopsychosocial profile will be administered a comprehensive substance use screening. A history notable for substance use challenges will be communicated to the prescribing physician. Prescribing physicians will order a urine drug screening and review this and the results of a PDMP query with each individual prior to prescribing benzodiazepines. Each month the medical director/QA committee will review a sample of _ charts to assure adherence."

Finally, it is important that policies are individualized to best reflect the needs of each program and the population served.

Appendix N: Guidance on Peer Support Policies

A policy must be in place that indicates how peer support/peer culture will contribute to the overall culture of the program. The policy must include:

A. The **Purpose**; of peer culture and peer support staff.

B. The **Policy**; concerning how peers participate in the planning, developing, delivering and evaluating program content and outcomes. What is the function of the peer support staff?

C. The **Responsibility**; as to how is the power of peer culture/peer support being recognized? What opportunities are created for peers to support each other? Are you hiring peer support staff? What opportunities do peers have to engage in active leadership roles at all levels of the program? What collaborations or relationships been established in the community to link individuals to other behavioral health agencies or recovery support groups?

D. The **Procedure**; to create an initial, welcome environment for individuals into the program. What is the process to orient individuals on program structure and expectation for a successful experience? Do individuals have input on deciding groups and training courses based on their recovery plan? What continuing support plans to you have in effect? What is the plan to foster successful integrations of peer support staff into your program? Are alumni mentoring apart of the program? Do individuals receive information about grievance procedures?

A policy must be in place that includes supervision of all peer staff and that all peer staff supervisors receive the CPS supervisor training and be familiar with the CPS Peer Toolkit. https://dbhids.org/peersupport-toolkit/Click here to access the peer support toolkit.

Appendix O: Written Policy Requirements

All providers must have in place the following policies and must also ensure adherence to the identified policies. At minimum all policies should include which individuals/members the policy applies; which staff are responsible for each procedure; and how implementation will be assured. Policies should be reviewed occasionally to ensure continued relevancy to the population served and programmatic structure.

1. Clinical Supervision Policy

A Clinical Supervision Policy must be in place that indicates all clinical and direct care staff members receive recovery/resilience-oriented supervision. The policy must describe how supervision is focused on improving outcomes for people receiving services, as well as addressing staff strengths and challenges. The policy must also describe how supervision sessions support the individualized learning plan for each staff member. *Please reference Appendix I within this document for further specifications around supervision.*

2. Performance Evaluation Policy

A performance evaluation policy must be in place that indicates the requirement of performance evaluations occurring for all staff. The policy must indicate that after the staff person's probationary period ends, performance evaluations are conducted on an annual basis, at a minimum. Further, the policy must provide language about the areas for staff improvement that are identified as part of the performance evaluation and that are linked to the individual's ongoing learning plan or yearly goals.

3. Feedback from Participants, Families, Allies and Program Alumni Policy

A policy must be in place to ensure that there is ongoing feedback from participants (to include children, youth and adults), families, allies and program alumni. The feedback obtained should be both quantitative and qualitative feedback. The policy must include language about the findings from the data collection and feedback from a sampling of participants, families, allies and program alumni that are analyzed on a quarterly basis.

4. Measuring the Effectiveness of Services Policy

A policy must be in place that indicates that agencies measure the effectiveness of the services provided. This policy must include language about how disparities concerning access, engagement, service quality, and outcomes are routinely assessed and monitored.

5. Role and Impact of Peer Support Policy

A policy must be in place that indicates how the role and impact of peer support are continuously evaluated to determine their contribution to the culture of the program. The policy must include language about how the peer support staff, volunteers and people receiving services are involved in this ongoing task. Additionally, a supervision policy must be in place that

specifies that all peer staff members must receive recovery/resilience-oriented supervision.

6. Completion of High-Risk Behavioral Assessments Policy

A policy must be in place that addresses the need for high risk behavioral assessments to be completed for all individuals, including the screening for suicidality, homicidality, and any biomedical/physical concerns which may require a medical evaluation and assessment of withdrawal-symptom severity. The policy must include language that indicates the screening for suicidality and 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. The policy must indicate that the agency has measures in place for high risk screens, to include possible referrals for an emergent evaluation. All providers offering substance use services funded through DDAP must have the specified emergent care questions as identified in the DDAP Treatment Manual, Section 9.01. Additionally, the policy must include language about incident reporting, which occurs at the state and CBH level if a suicidal/homicidal attempt is made.

7. Policy on the Prescribing of Benzodiazepines

This policy is required for all providers who prescribe medications. Please reference Appendix M of this document for guidance and further specifications.

8. Policy on the Use of Antipsychotic Medication in Children and Youth

This policy is required for all providers who prescribe antipsychotic medications to children and youth. Please reference the DBHIDS-CBH Provider Bulletin #18-12. *Please Note: this policy is required only for those providers who serve children and adolescents.*

9. <u>Policy on the Use of Psychotropic Medications in Children and Adolescents (FDA approved</u>
and off-label)

A policy must be in place 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 reference the DBHIDS -

CBH Provider Bulletin #10-03. *Please Note: this policy is required only for those providers who serve children and adolescents.*

10. <u>Policy Regarding the Screening for and Treatment of the Components of Metabolic</u>

Syndrome

There must be a policy in place regarding the Screening for and Treatment of the Components of Metabolic Syndrome. This policy is required for all providers who prescribe medications. The policy must address all required elements and medication management progress notes must reflect the practice of this policy. Please reference the DBHIDS Provider Bulletin #07-07 for further guidance and specifications.

11. <u>Policy on the Full Range of Treatment Services Provided by Methadone Treatment Centers</u> A policy must be in place that indicates methadone treatment centers (Medication-Assisted
Treatment Centers) provide, or be able to refer to, a full range of services including vocational, educational, legal and health; *Note: this does not apply to Suboxone.* The policy language must include that treatment centers will comply with all state and federal licensing regulations. Further, the policy must include language about how the agency offers 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.

12. <u>Policy on Preventative and Diagnostic Healthcare</u>

A policy must be in place that indicates how agencies assist participants in accessing critical preventative and diagnostic healthcare services through referrals or coordination with community healthcare supports.

13. <u>Policy Related to On-site Maintenance, Administration and Prescription of Naloxone</u> A policy must be in place at all behavioral health provider agencies regarding the administration of Naloxone. The policy must include language ensuring that there is staff equipped (via training) to identify persons in need of and to promptly administer Naloxone as indicated. Additionally,
such policies and procedures should ensure the acquisition, storage, monitoring, administration, and safe disposal of used and expired Naloxone. Please reference the DBHIDS Provider Bulletin #16-04 for further guidance.

14. Tobacco Free Policy

This policy is required for all levels of care including those providers offering substance use services funded through the Pennsylvania Department of Drug and Alcohol Programs (DDAP). The policy should include language stating that the use of tobacco products is prohibited on campus including not only individuals receiving services but also staff members, visitors, contractors, etc. The policy should address procedures for staff training, tobacco treatment for individuals receiving services and staff, as well as how they plan to ensure adherence to the policy. Additionally, the policy should detail a description of the plan to communicate the policy to individuals receiving services, staff, visitors, contractors, etc.

15. Confidentiality Policy

This policy must be in place and must address the following areas: release of individual identifying information, storage and security of clinical records, computer security of clinical records, staff access to records, confidentiality training for all applicable staff, disciplinary protocols for staff violating confidentiality regulations, revocation of consent, and notification that re-disclosure is prohibited without proper consent.

16. Sexual Harassment Policy

This policy is required for all DDAP funded providers as noted in the DDAP Operations Manual 7.04. The policy must include language ensuring that employees are aware of the policy and that sexual harassment will not be tolerated and employees who violate the policy will be disciplined.

17. Policy Regarding the Review of Interim Services

This policy must be in place for all DDAP funded providers who serve both pregnant women and Injection Drug Users. The policy must clearly detail the procedures for ensuring the provision interim services for the identified individuals if they are not able to be admitted within 14 days after the completion of the level of care assessment. These interim services must be provided and arranged for within 48 hours of the level of care assessment. *Please reference the DDAP Treatment Manual, Section 6.01 for further guidance.*

18. Policy on Priority Populations

This policy must be in place for all DDAP funded providers. The policy must specify the provider's priority populations; which should be in the following

order, 1. Pregnant Injection Drug Users; 2. Pregnant Substance Users; 3. Injection Drug Users; 4. Overdose Survivors; and 5. Veterans. The policy must include language stating that all individuals identified as part of the priority population are offered admission to the recommended level of care immediately. *Please reference the DDAP Treatment Manual, section 6.00 for further guidance.*

19. Single County Authority (SCA) Procedures Policy

All DDAP funded providers must have a policy in place regarding the Grievance and Appeal process as it relates to the Single County Authority. *Please reference the DDAP Treatment Manual, for further guidance.*

20. Family Inclusion Policy

This policy must be in place and address the following areas: obtain release of information; contact the family; offer ongoing supports, guidance, and resources to all families; engage the participant in conversation around family; engage family in recovery planning; provide all staff regular training and supervision around family inclusion; formally monitor ongoing staff family inclusion practices; collect regular feedback from family; and recruit family to serve on boards, committees, or other advocacy groups. Please reference the Family Resource Network (FRN) Family Involvement (FI) 2018 Best Practice Standards for further guidance.

21. Language Access Policy

This policy is in draft and is anticipated to be published during the 2019 calendar year. NIAC will add this to the list of required policy to be reviewed in 2020. Communication on finalized policy will be shared via CBH and DBHIDS News-Blast. https://cbhphilly.org/cbh-providers/cbh-newsblast-how-to-subscribe/Subscribe to the News-Blast here.

Appendix P: Network Recognition Levels

Network Recognition Level	Total Level of Care Score	Outcomes and Next Site Visit	Potential Network Incentives/Restrictions
Provisional Status	**Replaces 3-month status**	**Does not meet minimal NIAC approval standards.** Mandatory CBH Quality Management teaming required. Outcome to be determined by CBH Teaming.	Incentives and restrictions to be determined by funding source.
Warning Status	**≤59-69%**	Intermittently meets minimal NIAC approval standards**.** A **Six-month status** is awarded by CBH Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP. CBH Quality Management Department teaming to determine next steps along with an onsite Performance Improvement Plan (PIP) visit by NIAC with a mandatory technical assistance recommendation and referral from NIAC.	Incentives and restrictions to be determined by funding source.

Level 1: **Basic Approval Status**	**70- 79%**	Mets minimal NIAC approval standards. A **One-year status** is awarded by CBH Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP along with an onsite PIP visit by NIAC.	Incentives and restrictions to be determined by funding source.
Level 2: **Sufficient Approval Status**	**80-89%**	Satisfies NIAC approval standards. A **Two-year status** is awarded by the CBH Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP.	Incentives to be determined by funding source.
Level 3: **Excellent Approval Status**	**≥90%**	Fully meets network approval standards. A **Three-year status** is awarded by Credentialing Committee with information provided by NIAC, Compliance, Quality Management, OMHSAS, and DDAP.	Incentives to be determined by funding source.

Appendix Q: NIC 3.0 Fact Sheet

DBHIDS Network monitoring processes have been transformed to be more focused on improving quality care, measuring outcomes to foster excellence in service delivery and ensuring alignment with Population Healthcare approaches

Self-Appraisal: (Appendix E)

- **Pre-visit data submissions required for the following high-risk behaviors**
    - Suicidal/homicidal attempts
    - Physical/mechanical/chemical restraints
    - Elopements
    - Naloxone administration
    - Bio-medical/physical health concerns requiring urgent care

• Pre-visit documentation submissions required of all Assessment Forms/Templates

- **Foundations of Excellence in Service Delivery**
    - When individuals with forensic experiences present to the agency programs, what methods are utilized to support these individuals?
- **Domain 2: Screening, Assessment, Service Planning and Delivery**
    - How does the agency ensure internal compliance is monitored and maintained for all policies required by DBHIDS-CBH?
- **Domain 4: Community Connection and Mobilization**
    - For Drug-Free Substance Use Treatment Providers: Describe any formal referral agreements with Medication Assisted Treatment (MAT) providers.

Network Recognition Levels: (Appendix P)

Network Recognition Level	Total Level of Care Score	Outcomes and Next Site Visit
Provisional Status	Replaces 3-month status	Does not meet minimal NIAC approval standards.

Warning Status	≤59-69%	Six-month Status
Level 1: Basic Approval Status	70- 79%	One-year status
Level 2: Sufficient Approval Status	80-89%	Two-year status
Level 3: Excellent Approval Status	≥90%	Three-year status

- **Technical Assistance Process**
  - Providers with a Total Level of Care Score within the “Warning Status” and “Provisional Status” level will be given mandatory technical assistance recommendation and referral from NIAC.

Appendix Q: NIC 3.0 Fact Sheet Cont'd.

***DBHIDS* Mandatory Outcome Measures: (Appendix G-V)**

- It is recommended that providers select at least one outcome from each of the categories listed below. NIAC will collect the reported data and review its implementation as part of the recredentialing process.

PREVENTION and EARLY INTERVENTION	TREATMENT and SERVICES	HEALTH ECONOMICS	INFRASTRUCTURE and INTELLIGENCE	INNOVATION
4 Focus Areas	5 Focus Areas	3 Focus Areas	2 Focus Areas	2 Focus Areas

New Practices

- Domain 2; Standard D; Practice 6: Benzodiazepine Prescribing Policy
- Domain 4; Standard C; Practice 4: Provider Bulletin #16-04 On-site Maintenance, Administration and Prescription of Naloxone
- Domain 4; Standard C; Practice 5: Tobacco-Free Policy required for ALL levels of care
    - The provider screens and assesses individuals for tobacco use; additionally, individuals are offered tobacco use recovery treatment and/or referred to external programs
- Single County Authority (SCA) Addendum; Practices 1-8, aligns with DDAP requirements

Revised Practices

Domain 2: Screening, Assessment, Service Planning and Delivery

Almost all individuals receiving services, regardless of age, have a prior history of traumatic experiences. These practices have been revised to bring awareness to all forms of trauma, including the adult population through the continued efforts of the Population Health Transformation along with combating the increasing rates of Adverse Childhood Experience (ACE) scores. It is imperative that we provide appropriate service delivery and treatment as we continue to improve the lives of all Philadelphians we serve.

- **Standard A:** *Conducting Strength-Based Assessments and Evaluations*
    - Practice 3. All individuals are screened for trauma (including all forms of abuse)

- Practice 4. All individuals, regardless of age, are screened for evidence of bullying (physical, verbal, cyber, etc.) both as perpetrator and/or victim.

- **Standard B:** *High Risk Behavioral Assessments (Urgent Screening)*

This practice was broken into three separate practices to ensure that all components of high-risk behavioral assessments are captured within the scoring process.

- Practice 1. High risk behavioral assessments are completed at intake for all individuals, regardless of risk, including the screening for suicidality and homicidality; biomedical/physical concerns.
- Practice 2. If an individual screens positive for current (SI/HI within the last 24 hours) high-risk behavior, a more in-depth assessment of the specified behavior is required to be completed and maintained in the clinical record.

Appendix Q: NIC 3.0 Fact Sheet Cont'd.

- Practice 3. An incident reporting system must be in place for all high-risk behaviors addressed; including suicidal/homicidal attempts made, physical/mechanical/chemical restraints, elopements, suspected child abuse, Naloxone administration, and biomedical/physical health concerns requiring urgent care, etc. Incident reporting must occur per guidelines at the state, city, and CBH level. Reference: Provider Bulletin #1813.

- **Standard C:** *Advancing Excellence in Resilience/Recovery Planning and the Delivery of Services*

- Practice 5. A safety/crisis plan is in place for all children, youth, adults and families experiencing high-risk behaviors and/or at risk for ongoing traumatization. A detailed safety/crisis plan captures the following components; triggers, early warning signs, supports (names/phone numbers), what the individual can do to de-escalate on their own, and specifics of who they can call or go to if additional support is needed.

- **Standard D:** *Ensuring Safe and Effective Medication Practices*
    - Practice 4.

There is compliance with Provider Bulletin (#18-12) DBHIDS-CBH Clinical Guidelines for the Prescribing and Monitoring of Antipsychotic Medications for Youth concerning prescribing and treatment practices to include; psychiatric evaluation, medication side effect monitoring (e.g. involuntary movements, adverse metabolic and cardiac effects), behavioral health services, and consent and assent (CBH Bulletin # 1003).

Written Policy Requirements: (Appendix O)

- Use of Antipsychotic Medication in Children and Youth Policy
    - This policy is required for all providers who prescribe antipsychotic medications to children and youth. Please reference the DBHIDS-CBH Provider Bulletin #18-12.

Note: this policy is required only for those providers who serve children and adolescents.

- Data collection of medication monitoring (Appendix G-III).
- Language Access Policy to be reviewed in 2020.

Family Resource Network (FRN): (Appendix J)

- Certification of 2018 Best Practice Standards Involving Participant-Identified "Family" in Behavioral Treatment and Recovery Programs.
    - Family Inclusion certification is designed to help providers implement best practices in family inclusion.
    - The term "family" includes everyone (other than treatment staff) who may be important to participants' recovery and treatment: family members, friends, relatives, roommates, spouses/partners, clergy, etc.
- 2018 Best Practice Standards is a DBHIDS Mandatory Outcome Measure (Appendix G-V).

Appendix Q: NIC 3.0 Fact Sheet Cont'd.

Mandatory NIC Training courses: (Appendix H)

- Peer Culture/Peer Support Training.

- Resource links are incorporated to assist providers in identifying education opportunities for staff.
- All mandatory NIC training courses are required to be completed upon hire and annually thereafter.
    - It is encouraged that training courses be incorporated into annual performance evaluations to ensure completion occurs on an annual basis.

Performance Improvement Plan (PIP) Process:

The PIP process serves to identify those areas that would benefit from increased alignment with the Network Inclusion Criteria (NIC) practices. ALL providers, regardless of status awarded, must respond to the identified PIP items noted within the written report.

- A PIP Response is required within 30-days from the final report date and should be submitted to the attention of Operations Specialist via the email address provided in the report or via mail to Community Behavioral Health (CBH) located at 801 Market Street, 11th Floor, Philadelphia, 19107.
- Please feel free to collaborate with your NIAC Team Facilitator (TF) contact during this process should questions arise.
    - If the NIAC TF contact is unavailable, please contact:
        - Director of NIAC at 267-602-2005.
        - Health Program Manager of NIAC at 267-602-2006.
- Please be advised, PIP responses not received within 30 days, will be deemed a quality concern and submitted to CBH for further investigative actions.