

ALLEGHENY COUNTY
DEPARTMENT OF HUMAN SERVICES



CONTRACT SPECIFICATIONS MANUAL
FOR SERVICES PURCHASED FOR CONSUMERS OF
THE OFFICE OF BEHAVIORAL HEALTH
ADULT MENTAL HEALTH SERVICES AND CHILD AND ADOLESCENT SERVICES

FY 2015-2016

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INTRODUCTION

The Contract Specifications Manual provides the special terms and conditions which are applicable to the service or services being provided through an agreement between the Allegheny County Department of Human Services and a contracted Service Provider. By reference in the agreement, the applicable chapters or provisions of the Contract Specifications Manual are incorporated therein.

Further, the manual identifies:

- A. Any particular forms or procedures that the SERVICE PROVIDER must comply with in order to assure the COUNTY's compliance with the requirements of the funding source(s).
- B. Service Category Names and Codes.
- C. Cost Centers and their relationship to the Service Names/Codes.

The terms, conditions, forms, and procedures in this manual are subject to change from time to time as required by law and shall be amended or modified by written notification from the COUNTY to the SERVICE PROVIDER.

In addition, SERVICE PROVIDER is required to comply with the Terms and Conditions of additional contract specifications manuals, including, but not limited to:

- 1. DHS General Contract Requirements
- 2. DHS Contract Specifications Manual on Payment Provisions, Budget and Invoices
- 3. Minority/Women/Disadvantaged Enterprises (M/W/DBE)
- 4. Instructions for Completing Contract Facilities Worksheet

CHAPTER 1: SERVICE PROVIDER CONDITIONS

SERVICE PROVIDER shall adhere to the following terms and conditions as put forth in the “Mental Health and Mental Retardation Act of 1966” Special Session No. 3, October 20, 1966 P.L. 96, No. 6, 50 P.S. (4101-4704) 301 (d), the “Mental Health Procedures Act”, Act 143 of 1976; 50 P.S. §7101 et seq. which specifies the services which are to be made available under the Allegheny County Department of Human Services by the local authorities; and, for which the County contracts with SERVICE PROVIDERS.

A. Definitions:

The following definitions shall apply throughout this Manual:

1. “Act” refers, as applicable, to the “Mental Health/Mental Retardation Act of 1966”, or the “Mental Health Procedures Act of 1976”.
2. “Regulations” refers, as applicable, to Regulations promulgated under the Act by the Offices of Mental Health/Mental Retardation, Pennsylvania Department of Public Welfare, and Allegheny County’s Department of Human Services.
3. “Resident”, “Consumer”, and “Subject” refer to persons counseled, treated or rehabilitated; including all persons formerly counseled, treated or rehabilitated.

B. Quality Statement:

Allegheny County, Office of Behavioral Health has made a commitment to promoting recovery-oriented services to consumers of behavioral health services. The primary intent of this initiative is to foster hope and autonomy for behavioral health consumers. In order to achieve these ideals, contracting providers should demonstrate that their services are consistent with these processes. In the current contract year, providers should be able to show that they are continuing to develop a service system that is compatible with recovery principles. Examples of how this may be demonstrated include:

1. Promote hope for and reinforce the ability of the consumer to recover
 - a) Provide opportunities for consumer to participate meaningfully in their treatment plan and establish long-term goals that maximize their potential
2. Explain choices (housing, services, programs, etc.) and offer the consumer guidance in the selection process
 - a) Develop a collaborative, mutual approach to problem-solving processes that emphasize the provision of all possible options and choices
3. Promote consumer participation in peer support and advocacy groups;
 - a) Create a service environment that is conducive to consumer participation in mutual support activities and advocacy efforts

4. Assist the consumer to define his/her Advance Directives
 - a) Establish processes through which consumers are assisted in defining personal advance directives and a process to assure that these directives are respected
5. Facilitate participation in recovery-oriented training events
 - a) Create staff training programs and competency requirements for staff;
6. Encourage consumer participation in administrative functions
 - a) Establish processes through which consumers may participate in behavioral health administration, with an emphasis on continuous quality improvement processes
7. Improve communication and understanding between providers and consumers of behavioral health services
8. Develop dialogues between consumers and providers related to recovery and quality improvements processes.
9. Practice in ways consistent with the Resiliency and Recovery Oriented Services standards and guidelines and Single Point of Accountability language in Appendices C, D, and F in this manual.

C. SERVICE PROVIDER will file with the COUNTY a report of any unusual incident, including HCSIS reporting, and agrees to cooperate with the COUNTY regarding any follow-up investigation including review of consumer records and the SERVICE PROVIDERS actions.

D. The COUNTY reserves the right to require the SERVICE PROVIDER to obtain prior authorization from Community Care as the County's agent for all selected services that are reimbursed on a fee-for-service basis, with ninety (90) days-notice. (See addendum)

E. Any changes to the services under the AGREEMENT that result in changes in the approved activities or the location of activities or the addition, reduction or deletion of services to be purchased by the COUNTY from SERVICE PROVIDER under the AGREEMENT must receive prior written approval from the Allegheny County Department of Human Services (DHS) Director. SERVICE PROVIDER requesting a change must submit a written request to the DHS Director and the DHS Deputy Director for the Office of Behavioral Health at least ninety (90) days prior to the anticipated change.

F. Performance Conditions

1. SERVICE PROVIDER shall be bound to comply with such review of all aspects of their respective programs as are required by all appropriate Federal, State, and County authorities. Such reviews and evaluations shall be made at reasonable times during the term of the AGREEMENT, and may include reviews by the Director of individual consumer records.
2. SERVICE PROVIDER shall permit an authorized designee of COUNTY to attend that portion of any and all such meetings affecting the program funded by the AGREEMENT, and shall provide COUNTY at SERVICE PROVIDER'S expense, with an accurate copy of that portion of the minutes of any such meeting within a reasonable time after its adjournment, and the SERVICE PROVIDER shall provide COUNTY with reasonable advance notice of the date, time and place of its Citizen Advisory Council meetings and Board meetings when appropriate;
3. SERVICE PROVIDER does hereby agree to provide promptly on the execution of the AGREEMENT, a full and complete copy of the bylaws of the Provider Corporation, certified to be a true and correct copy of the same by the Secretary or Assistant Secretary. SERVICE PROVIDER further agrees to promptly provide a certified copy of any changes in the by-laws which may be adopted by the corporation during the term of the AGREEMENT;
4. SERVICE PROVIDER shall supply COUNTY with such consumer and service information as shall be duly required by COUNTY for the purposes of management, accountability, and compliance with State and Federal reporting mandates, provided that COUNTY'S requests are in conformity with applicable laws on consumer confidentiality and that they include appropriate technical specifications as to the manner(s) and mode(s) in which information will be accepted. SERVICE PROVIDER may utilize outside consultants and vendors in designing and/or operating its management information system, but SERVICE PROVIDER'S obligation to COUNTY is not transferable to any other party. Significant and/or persistent failure to supply requested information shall result in financial penalties or other sanctions unless waived by the Director.
5. OFFICE OF BEHAVIORAL HEALTH shall monitor and evaluate performance through:
 - On-Site Monitoring and Contract Management – announced and unannounced site visits will occur for all agency programs receiving funding to provide mental health services

- Including but not limited to, a review of Health and Safety assessment, Provision of Services, Review of Data, Quality of Services, Fiscal Review and Consumer Satisfaction.
- Conducted throughout the fiscal year.
- Including but not limited to Programmatic review, Health and Safety Assessment, On-Site Inspection and Consumer Satisfaction.
- Ongoing review of Incident Management information.
- Review of Service provider having made timely response to requests for information from the Department of Human Services Office of Behavioral Health.

G. Collection of Liability and Other Revenue Collections of SERVICE PROVIDER shall be based on the appropriate Department of Public Welfare Regulations (PA DHS), which indicates the various forms of liability for services.

1. SERVICE PROVIDER shall have an affirmative duty to pursue all reasonable sources of collection, both from consumers and from an obligated third party, where appropriate, within a reasonable time after rendering of the services, and with due diligence.
2. The assessment of consumer liability and fee collections from consumers or their legally responsible relatives, where applicable, is the responsibility of the SERVICE PROVIDER and must be performed in accordance with the Chapter 4305 Liability for Community Mental Health and Mental Retardation Services Regulations. The abatement of consumer liability shall be initiated by the SERVICE PROVIDER with the final resolution of the abatement process being the responsibility of the DHS Director.
3. All Mental Health Residential providers that directly provide rent, utilities and/or food to consumers shall comply with the provisions of the Chapter 6200 Regulations regarding collections of room and board payments per the standard room and board contract.

COMPASS Community Partner Overview

All providers need to assertively pursue all private and public funding and to enroll as “Compass Partners” with the County Assistance Office.

1. Organizations such as hospitals, church groups and other community based groups that help Pennsylvania residents apply for health and human services can register become a COMPASS Community Partner.
2. By registering as a COMPASS Community Partner, your organization can initiate and track applications through the COMPASS Community Partner Dashboard. This quick reference guide provides you the step-by-step instructions to register online to become a COMPASS Community Partner.
3. There are three main steps to registering:
 - Register your organization as a COMPASS Community Partner.
 - Register at least one, but no more than four individuals as delegated administrators. These individuals will have the ability to approve or reject additional COMPASS users within your organization.
 - Register additional COMPASS users as needed.
4. Please note: Microsoft Internet Explorer 6.0 Service Pack 2 is the lowest supported browser.

The registration application can be found here:

<http://www.compass.state.pa.us>

ADULT BEHAVIORAL HEALTH PROGRAM STANDARDS

- Acute Partial Hospital
- Certified Peer Support
- Community Treatment Team
- Diversion and Acute Stabilization
- Inpatient
- Outpatient Services
- Psychiatric Rehabilitation Clubhouse Model

These all have specific program standards and can be found at

<http://www.ccbh.com/>

H. Personnel Action Plan The SERVICE PROVIDER shall employ all positions as required to fulfill the AGREEMENT and in conformity with the Allegheny County Personnel Action Plan, subject to available funding for all program funded cost centers. SERVICE PROVIDER must submit to COUNTY annually, with the AGREEMENT, a copy of their salary and fringe benefit package in conformance with the PA DHS maximum reimbursement of salaries and fringe benefits. This paragraph is applicable to SERVICE PROVIDERS whose positions are funded through a program-funded

agreement. SERVICE PROVIDERS, whose agreements are fee-for-service, in whole or in part, are required to comply with this provision for all staff positions that are not 100% attributable to the fee-for-service portion of services.

- I. **Consumer Right to Appeal** SERVICE PROVIDER must implement the consumer right-to-appeal as policy regarding treatment or payment decisions. This policy shall be given to consumers at intake, posted in conspicuous places throughout the agency, and reviewed on a regular basis with the consumer during the course of the year.

- J. **Citizen Participation** SERVICE PROVIDER agrees to develop and implement a Citizen Participation Policy in compliance with the "Citizen Participation Policy" adopted by the Allegheny County Mental Health/Mental Retardation Board in January 1987. By means of the plan so developed and implemented, SERVICE PROVIDER shall actively seek citizen input and participation in planning, governance, policy formulation and such other appropriate activities as shall provide meaningful citizen/community participation in the provider organization. SERVICE PROVIDER shall make available to COUNTY upon request all such plans for citizen participation and input.

- K. **Consumer Satisfaction** SERVICE PROVIDER will be expected to have a Quality Management Policy that includes Consumer/Family satisfaction assessments. SERVICE PROVIDER agrees to allow access to and provide interview space for County approved consumer satisfaction activities at a minimum of annually.

- L. **Human Experimentation** All experimentation with human subjects involving any physical or mental risk to those subjects shall be prohibited without all of the following:
 - 1. Prior written approval of the Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS), subject to all applicable laws, statutes, and regulations;
 - 2. Prior informed and voluntary written consent of the subject;
 - 3. Prior informed and voluntary written consent of his/her parents or legal guardian, if the consumer is deemed to be a minor or incompetent.
 - 4. Each potential subject shall be informed prior to his/her consent that refusal of consent will not result in the loss of any benefits to which the subject is otherwise entitled to from the Federal Government, Commonwealth, COUNTY, SERVICE PROVIDER, or any third party insurer.

CHAPTER 2: INSTRUCTIONS FOR COMPLETING MH CONTRACT BUDGET

An initial budget is required for each contract year. In addition, SERVICE PROVIDER is required to prepare and submit a revised budget with each modification and/or amendment to the agreement that is executed throughout the term of the agreement.

Budgeting forms and instructions can be found in the DHS Contract Specifications Manual on Payment Provisions, Budgets and Invoicing. SERVICE PROVIDER is required to obtain a copy of said manual from the DHS Website or request a hard copy in writing.

CHAPTER 3: PROCUREMENT AND PROPERTY RIGHTS

A. Definition: As used in this Article, the term “fixed assets” will be defined as: “Major items, excluding real estate, which can be expected to have a useful life of more than 1 year, or which can be used repeatedly without materially changing or impairing their physical condition by normal repair, maintenance or replacement of components with a purchase price of \$5,000 or more. All vehicles, regardless of purchase price, shall also be defined as a fixed asset.

B. Procurement of Fixed Assets – Title of all fixed assets, and materials, plans and procedures purchased in part or in whole with funds from this **AGREEMENT**, shall be identified in accordance with applicable state regulations governing the **SCOPE OF SERVICES**. Fixed assets for which the **SERVICE PROVIDER** will hold the title must be obtained at the lowest practicable cost, using a system of competitive bidding, written estimates, sole source purchases and/or required justifications in accordance with applicable state regulations.

C. Annual Inventory – **SERVICE PROVIDER** shall conduct an annual physical inventory and maintain an up-to-date inventory of fixed assets purchased in whole or in part with funds from this **AGREEMENT** which shall vest during the term of this **AGREEMENT** with the **SERVICE PROVIDER** and shall automatically divest upon the termination or cancellation of the **AGREEMENT** and vest with **COUNTY**. **COUNTY** may, in its discretion, in whole or in part according to the percentage of contribution, and within one hundred and twenty (120) days after the expiration of this **AGREEMENT**:

1. Take possession of said fixed assets and reimburse any other funding sources according to their percentage of contribution based upon fair market value as determined by an independent appraisal;
2. Direct that said fixed assets be sold pursuant to an independent appraisal reflecting an acceptable fair market value with the proceeds of the sale retained by **COUNTY**.

3. Allow retention by the **SERVICE PROVIDER** upon proportionate payment to **COUNTY** of the share contributed by **COUNTY** as determined by the fair market value in accordance with an independent appraisal. Said independent appraiser to be selected by **COUNTY** and the **SERVICE PROVIDER**.

At all times during the performance of this **AGREEMENT** and within one hundred and twenty (120) days after termination or cancellation, the **SERVICE PROVIDER** shall not sell, lease, donate, or otherwise dispose of any fixed assets purchased with funds obtained pursuant to this **AGREEMENT** without prior written permission of **COUNTY**.

D. Depreciation of Fixed Assets – **SERVICE PROVIDER** may budget and claim depreciation in its budget on such fixed assets, to which it holds title, as may be acquired through funds other than revenue pursuant to **COUNTY AGREEMENT** and service dollars reflected in the gross **AGREEMENT** amount with **COUNTY**. Any depreciation allowance must be placed in a reserve account in accordance with generally accepted accounting practices and attested to by their auditor of record. Replacement of any asset that has been previously expensed to **COUNTY** must have **COUNTY** prior approval. The depreciation allowance must also be in compliance with applicable state regulations.

E. Recordable Interest

1. **SERVICE PROVIDER** agrees to provide a recordable interest to the **COUNTY** in an amount equal to the **COUNTY'S** participation pursuant to this **AGREEMENT** in down payments, and amortization of the principal of any newly purchased property, previously purchased property which has not been paid off, and any property in which the **COUNTY** funds improvements and renovations. **SERVICE PROVIDER** shall execute and deliver any documents necessary for securing and recording the **COUNTY'S** interest either as a judgment or a mortgage as the **SERVICE PROVIDER** may select, so long as the **COUNTY'S** interest is adequately protected.
2. **COUNTY** shall not execute on the recordable interest unless the subject property is sold or **SERVICE PROVIDER** no longer contracts with **COUNTY**. **COUNTY** recognizes that it may be necessary for **SERVICE PROVIDER** to sell existing properties to acquire new properties, and **COUNTY** agrees to transfer its recordable interest to the new property provided **COUNTY'S** equity is adequately protected and the new property is used for Mental Health and/or Mental Retardation purposes. If a single property is sold, only the amount of participation attributable to that property

shall be at issue. Should the property be sold for less than the original improvements and renovations, **COUNTY** shall decrease its participation amount in proportion.

3. **COUNTY** also recognizes the need for **SERVICE PROVIDER'S** to borrow funds and shall waive its position, if its interest is adequately protected, to facilitate borrowing. SSI rental payments shall not be considered **COUNTY** participation since such payments do not involve funds provided through the **COUNTY**.
4. The **COUNTY'S** interest in property owned or being purchased by **SERVICE PROVIDER** or related parties under prior contracts shall be the subject of future negotiations.

F. Renovations and Improvements - Minor renovations, improvements, repairs, or maintenance, cost of which is less than \$10,000, may be expensed or amortized. Major renovations, improvements, repairs and maintenance may only be expensed with **COUNTY** prior approval. If these are not used in the **DEPARTMENT** for five years, that unamortized portion of major renovations, improvements, repairs or maintenance funded by **COUNTY** shall be reimbursed by **SERVICE PROVIDER** according to **COUNTY'S** percentage of contribution.

G. Preservation of Fixed Assets - **SERVICE PROVIDER** shall maintain and administer in accordance with sound business practices a program for the maintenance, repair, protection, preservation and insurance of all fixed assets so as to assure its full availability and usefulness.

H. Exclusive Use of Fixed Assets - Any fixed assets purchased under this **AGREEMENT** shall, unless otherwise provided herein, or approved in writing by the **DEPARTMENT**, be used only for the performance of this **AGREEMENT**.

I. Loss Proceeds - In the event that **SERVICE PROVIDER** is indemnified, reimbursed or otherwise compensated for any loss or destruction of or damage to the fixed assets, **SERVICE PROVIDER** shall use the proceeds to repair, renovate or replace the fixed asset involved, or shall credit such proceeds against the cost of the work covered by the **AGREEMENT** or shall otherwise reimburse the **DEPARTMENT** as directed by the **DEPARTMENT**.

J. Forms and Additional Instructions – can be found in the DHS Contract Specifications Manual on Payment Provisions, Budgets and Invoicing. The manual is available on the Service Provider Information Page of the DHS Website.

APPENDIX A: CASSP CORE PRINCIPLES

Child and Adolescent Services System Program (CASSP) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles are summarized in six core statements.

1. Child-centered: Services meet the individual needs of the child, consider the child's family and community contexts, and are developmentally appropriate, strengths-based and child-specific.
2. Family-focused: Services recognize that the family is the primary support system for the child and participates as a full partner in all stages of the decision-making and treatment planning process.
3. Community-based: Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.
4. Multi-system: Services are planned in collaboration with all the child-serving systems involved in the child's life.
5. Culturally competent: Services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of the child's and family's ethnic group.
6. Least restrictive/least intrusive: Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

APPENDIX B: MENTAL HEALTH FEE-FOR-SERVICE SERVICE TYPES SPECIALIZED SERVICES AND RATES BY COST CENTER

Please contact the Program Office for the most current rates.

Child and Adolescent Services – Michael Szymborski
(412) 350-4954 Michael.Szymborski@AlleghenyCounty.US

Adult Services – Regina Janov
(412) 350-3476 Regina.Janov@AlleghenyCounty.US

APPENDIX C: PERFORMANCE STANDARDS

Providers are expected to adhere to licensing regulations as well as program standards developed by Community Care Behavioral Health and/or the Office of Behavioral Health. Please contact Community Care Behavioral Health or the Office of Behavioral Health for the most recent standards.

APPENDIX D: ALLEGHENY COUNTY COALITION FOR RECOVERY GUIDELINES FOR DEVELOPING RECOVERY-ORIENTED BEHAVIORAL HEALTH SYSTEMS

Introduction

In July of 2003 the President's New Freedom New Freedom Commission published their final report, *Achieving the Promise: Transforming Mental Health Care in America*. Nine months earlier President George W. Bush declared, "Our country must make a commitment. Americans with mental illness deserve our understanding and they deserve excellent care." He charged the Commission to study the mental health service delivery system, and make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

The promise of the New Freedom Initiative is that a life in the community can be realized for everyone as mental health services and supports actively facilitate recovery, and build resilience to face life's challenges. The benefits to transformed systems will be felt across America in families, communities, schools, and workplaces. Recovery from mental illness is the expected outcome from a transformed system of care (Hogan, Michael, F., Introduction to the Report).

The Guidelines for Developing Recovery-Oriented Behavioral Health Systems are the product of the Quality Improvement Workgroup of the Allegheny County Coalition for Recovery (ACCR) in the spirit of the New Freedom Initiative. The paper's purpose is to facilitate reform through stimulating thought, discussion and practical suggestions for changing practices. The workgroup suggests that mental health and addiction practitioners as well as the organizations in which they work will develop and implement behavioral health recovery practices in a comprehensive way. These guidelines will assist in engaging administrators, boards, direct care staff and people and families in recovery who receive services in discussions about practices and approaches that will promote recovery for those who experience emotional and cognitive distress and/or unhealthy substance use or other addictive behaviors. We recommend that those individuals involved in governing, developing, managing or providing services, use these guidelines as a mechanism to further enhance the recovery of all those they serve and, we hope, make professional life more rewarding.

ACCR consulted numerous sources and listened to the stories of many people in recovery. Although definitions of recovery are quite individualized, common themes have emerged. For example:

- Recovery is about personal growth and restoration;
- Recovery allows the renewal of purpose, meaning and hope;
- Recovery is about revelation, acceptance, and self-awareness;
- Recovery is about dignity and self-respect;
- Recovery means independence, personal responsibility and productivity;
- Recovery involves tolerance, forgiveness and adaptability;
- Recovery is about connecting in a fulfilling way with a community of other people;
- Recovery is about establishing meaningful relationships;
- Recovery is a universal concept that can be used by anyone;
- Recovery is about overcoming stigma.

The Guidelines have various topic areas:

- I. **Administration** pertains to the aspects of recovery-oriented services that relate to agencies or organizations or to the broader policies and approaches of organizations.
- II. **Clinical Services** refer to those areas relating primarily to services traditionally delivered in clinical settings. Because recovery-oriented services emphasize integration of a variety of services, the intent is not to reinforce the separation of services, but rather to highlight some of the critical areas where recovery-oriented service delivery may differ from more traditional methods
- III. **Support Services** refers to a range of services that are generally outside of the traditional clinical settings, yet are very important to recovery. Supports need to be coordinated and integrated with the total care of the individual.
- IV. **Prevention** refers to health management programs that are in place to assist individuals in making healthy choices about diet, exercise, medication, stress reduction, substance use and other aspects of their lives
- V. **Conclusion**
- VI. **References**

Each subsection is composed of a general description of the recovery-oriented services approach to the topic area. Following the introductory paragraph for each topic is a set of two to four observable measures to serve as indicators of services that are recovery-oriented. Finally, we have included a section for references for further study.

We appreciate the many people who contributed to this document, and we acknowledge the numerous resources used in its development. We hope that these Guidelines will be easy to understand and use and that they will be helpful as we all continue the process of reinventing the ways we think about and deliver the services that help people recover from mental illness and addiction. Future revisions will undoubtedly include the wisdom gathered from the many people who will read and comment on this version. Comments and suggestions are always welcome. For more information please go to the Allegheny County Coalition for Recovery Website, www.coalitionforrecovery.org.

I. Administration

Recovery-oriented services require that the behavioral health agency be organized and administered in a way consistent with promoting recovery. In some cases this may involve restructuring basic administrative processes. Recovery oriented administration involves new kinds of relationships with people and families in recovery, significant others, and the broader community that is rooted in mutual respect. It is important to remember that significant others can include friends, partners, and peers. There are many ways to define family.

Organizational Philosophy and Strategic Planning

For organizations to successfully provide recovery-oriented services, they must state their commitment to the recovery philosophy in their mission statement. The organizational mission should state that individuals with mental illness and/or addictions can achieve recovery over time. The organization's strategic planning goals, mission and objectives must include the development and strengthening of the community of recovering persons.

Indicators:

- The people in recovery, family members and significant others participate in the strategic planning process defined above.
- People in recovery are paid for participating in planning activities whenever possible.
- Mission and vision statements clearly state a commitment to helping people enter recovery and a plan for achieving recovery-oriented services.
- The strategic plan outlines steps for developing recovery-oriented services.

Stigma within the Organization

Stigma is a barrier to recovery because it prevents people from being valued on the basis of their personal strengths. Eliminating stigma and discrimination necessitates those with co-occurring substance and other addictions are assessed and treated comprehensively wherever they first access services. Professionals must be aware of their own attitudes toward people with mental and emotional challenges or addictions and avoid stereotyping anyone. Stereotyping is the process of assuming that someone has a set of (usually negative) characteristics because of some other characteristic that they do have. Examples of stereotypes are, "all people wearing glasses are nerds," or "all people with mental illness are dangerous or unintelligent." These stereotypes are sometimes based on symptoms, difficulties or addiction(s). To accomplish eliminating internal organizational stigma, the organization must accept persons in recovery at whatever stage the person has achieved, and recognize that each person's progress is unique.

Indicators:

- People in recovery know they are understood and respected by the professionals who serve them.
- The successes of people in achieving their goals are recognized and celebrated.
- People in recovery are recruited and supported in meaningful participation at all levels of the organization and are participants in service provision, evaluation, budgeting, and governance.

- The administration supports and provides for training in Motivational Interviewing to aid staff in accepting people wherever they are on their journey to healing and health.

External Stigma

People with behavioral health issues are frequently stigmatized in their communities. Behavioral health professionals have a responsibility to prepare and assist individuals to live successfully in the community. Professionals should also lessen stigma by educating the community. This can include networking with community leaders and organizations and providing education and training events.

Indicators:

- The organization joins those they serve in raising awareness and actively combating stigma in the community.
- The organization encourages people in recovery to participate and take on leadership roles in local and regional advocacy groups.
- Community mental health and addictions professionals are well-informed and educate the community about the reality of recovery.

Training and Continuing Education for Service Providers

All mental health and addiction professionals must have a thorough understanding of recovery concepts and a grasp of the perspectives of people in recovery. Continuing education programs should include training on recovery principles. Orientation and on-going training should give professionals the opportunity to interact with those they serve in community settings. The organization's training standards and requirements should reflect both of these goals.

Indicators:

- Persons in recovery and professionals have opportunities to interact in the community, outside of clinical relationships.
- Professionals receive ongoing training on recovery and wellness principles and practices.
- People in various stages of recovery participate in the training of professionals.

Continuous Quality Improvement (CQI)

Continuous quality improvement is a process by which organizations make their practices more efficient and effective in producing valued outcomes. Although developed originally for business applications, many human service organizations use CQI techniques to monitor and improve their services. As those most affected by health care, the people in recovery are in the best position to identify improvement opportunities. They are also in the best position to develop and evaluate improvement plans. Therefore, quality improvement activities should involve them at every level. Providers can show respect by always compensating persons in recovery fairly for their participation whenever and to the extent that is possible.

Indicators:

- Persons in recovery are well represented in continuous quality improvement activities in significant and valued roles and are compensated for their participation when possible.
- The opinions and ideas of those in recovery are actually used by the organizations in identifying improvement areas and developing improvement plans.

Outcome Assessment

Service providers are being held more and more accountable for measurable outcomes. In recovery-oriented services it is the progress of the person in recovery and their personal growth that is recognized as a crucial part of service outcomes. Outcomes must measure concrete levels of function (like the number of days lived in the community and growth outcomes such as employment, trainings and education) and overall quality of life.

Indicators:

- Persons in recovery help to figure out what outcome indicators to measure and how they should be measured.
- Outcome results are shared with persons in recovery in terms they can understand.
- The organization uses results to improve services and programs.
- The organization stays up-to-date in the field.

II. Clinical Services

Clinical services are behavioral health services that are provided by a trained clinician such as a psychiatrist, master's level therapist or other behavioral health professional that support, promote and enhance the recovery process. It is hoped that multi-disciplinary teams include Certified Peer Specialists and/or Peer Specialists. Examples of clinical services include individual therapy, family therapy, and medications. Recovery-oriented services provide clinical services, in a way that promote personal responsibility, independence as a goal, informed choice and consent all with authentic community integration for the individual. Behavioral health services in the past have frequently fostered dependence rather than independence, and have segregated people rather than helping them to integrate with the community.

Empowerment

An important part of recovery-oriented services is the empowerment of individuals. People are empowered by active participation in developing their own care plan. Individuals should also participate in the overall design of services. They will experience increased self-esteem and a higher quality of recovery by taking part in the decision-making process. Self-esteem means that an individual regards him or herself positively and believes that he or she has value as a person. Recovery oriented service providers recognize that people have the right to make choices about their own care. Shared decision making includes matters such as level of treatment and medication management. People and families in recovery are capable and welcome accepting responsibility for making informed choices regarding their own care and the results of these choices.

Indicators:

- Choices made by individuals are respected by service providers.
- Individuals receive comprehensive and understandable information regarding service options and have opportunities to choose their services.
- Medication management is a shared decision making process whenever at all possible.
- Direct-care staff effectively educates and inform clients of their rights and responsibilities while establishing a relationship with them to help them become active in their own recovery.

Available Services

Individuals should be able to choose from a variety of services and service providers. Recovery oriented services encourage and develop self-sufficiency and decision making. Recovery oriented services are flexible and tailored to the individual. Services should include but not be limited to, individual and group therapy, psychiatric and social rehabilitation and skills building opportunities, different levels of service coordination, crisis management, and participation in medication management. Recovery oriented administration makes available Certified Peer Specialists and other Peer support to individuals. Prevention, health maintenance, and illness self-management principles guide all services.

Indicators:

- Service options support recovery and wellness and include self-management practices.
- A wide variety of service options and providers are available.
- Individuals and family members participate in agency decisions regarding resource use and service development.

Cultural Competence

Cultural competency is an important aspect for every organization in the current multi-cultural environment. The ability to provide services that are perceived as legitimate for problems experienced by the individual and interventions the individual is willing to accept because the service interventions are uniquely designed to tap into their cultural identity. (McPhatter, A.M.1997). Cultural competency begins with cultural sensitivity. A recovery-oriented clinician is aware of his or her own culture and that of her client. Culturally sensitive clinicians show respect for individuals and their unique cultural environment. They recognize that beliefs and customs are diverse and impact the outcomes of recovery efforts. Cultural factors may be an important area of strength for recovering individuals. Access to service providers with similar cultural backgrounds and communication styles supports individual empowerment, independence, self-respect, and community integration.

The US Department of Human Services, Office of Minority health has developed National Standards on Culturally and Linguistically Appropriate Services (CLAS) which can be accessed at:

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>
<http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

Indicators:

- Staff is culturally representative of the community being served.
- Staff meets established cultural competency standards.

Integration

Integrated care is the coordination and collaboration between physical and behavioral healthcare providers. This, of course, includes substance use disorders and other behavioral diagnoses. A recovery-oriented clinical health care professional considers all health conditions at the same time. Integrated care is person-centered and requires health care professionals to view each person holistically (mind, body, spirit, and in their community).

According to SAMHSA, “Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.”

Integrated care can occur in many different ways. For example, services can be co-located to allow for improved access and communications. Integrated care can also occur when a team of professionals work together with the same individuals or a professional with mental health or substance use training may provide all basic (mental health, substance use and physical health) services for each individual served.

Indicators:

- Service providers detect the presence of unhealthy substance use and mental health disorders through screening processes.
- Co-occurring mental health and substance use disorders are treated at the same time by the same clinician.
- Clinical staff demonstrate application of motivational interviewing in areas outside of traditional chemical addictions by applying it to eating disorders, fears of physical health care providers and dentists.
- Recovery-oriented services will value and promote a holistic approach to health maintenance and recovery. A holistic approach to recovery includes physical and mental recovery.
- Service providers assess a person’s physical health needs and link them as needed to physical health care providers such as Primary Care Physicians, dentists and the like.
- Recovery-oriented services are developmentally appropriate and support individuals in significant life transitions for example from adolescence to adulthood.
- Evidence of appropriate screening and referral is found in the treatment and service plans. Integrated plans show evidence of collaboration between physical health care professionals and mental health care professionals.
- Goals and objectives reflect the client’s choice in choosing the domain of change. Goals can be seen in areas such as blood glucose monitoring independence, weight loss, exercise and independent community involvement.

Substance Use Disorders

Whenever possible, treatments of substance use disorders are integrated in recovery-oriented clinical services. This can occur via collaboration with other providers, collocation of services or by professionals with training and experience working with individuals with co-occurring disorders.

Indicators:

- Service providers detect the presence of unhealthy substance use and mental health disorders through screening processes.
- Co-occurring mental health and substance use disorders are treated at the same time by the same clinician.
- Clinical staffs have training and demonstrated proficiency in the application of person-centered motivational interviewing.

Clinical staff have training and demonstrate an understanding of behavioral addictions in areas such as exemplified by gambling, sexual, cleaning, internet and/or shopping addictions.

Behavioral Health and Physical Health Services

Whenever possible, Behavioral Health and Physical Health should be integrated and holistic. This can occur via collaboration with other providers, collocation of services or by professionals with training and experience working with individuals with multiple healthcare needs.

Indicators:

- Recovery-oriented services will value and promote a holistic approach to health maintenance and recovery. A holistic approach to recovery includes physical and mental recovery.
- Recovery-oriented services will value and promote holistic approaches to health maintenance and recovery. Service providers assess a person's physical health needs and link them as needed to physical health care providers such as Primary Care Physicians, dentists and the like.
- Recovery-oriented services are developmentally appropriate and support individuals in significant life transitions for example from adolescence to adulthood.

Involuntary Treatment

Involuntary treatment is any treatment which the person does not choose. This may be treatment which has been ordered by a legal inpatient or outpatient commitment process, such as a "302 commitment" in the Commonwealth of Pennsylvania. It also refers more broadly to treatment or aspects of treatment which might be imposed on a person against his or her will. Individuals should be offered choices to the greatest extent possible with regard to their treatment plan. Services providers should encourage the transition to voluntary treatment status as soon as possible. The use of involuntary services is not compatible with recovery principles. Therefore, providers of recovery-oriented services will make every effort to minimize the use of involuntary treatment. When they are unavoidable, they should be used with great care. Involuntary treatment arrangements should occur in the least restrictive

environments possible and maintained for the shortest period possible. Individuals should be treated with compassion and respect during involuntary treatment.

Indicators:

- Individual advocacy liaisons are appointed to courts and involuntary treatment authorities.
- Involuntary treatment is rarely used. When used it should be treated as a sentinel event.
- Changes to voluntary services are facilitated.

Seclusion and Restraint

The use of seclusion and restraint should be used only in extreme situations where safety is threatened. Seclusion is a process by which a person is removed from their usual environment and kept separate from other people. Restraint includes a variety of procedures which keep a person from acting or moving freely. Some restraints are physical and some are chemical medications. When it is necessary, they should be kept to a minimum and should be implemented in the most humane manner possible. Seclusion and Restraint should never be used at the same time. Service providers should discontinue use of these measures as soon as possible.

Indicators:

- Crisis plans use a progression of techniques designed to calm down dangerous situations.
- Debriefing occurs after all incidents requiring restraint or seclusion.
- When seclusion or restraint is necessary, the following is expected:
 1. It is brief and rare.
 2. Organizations have related policy and procedures in place to minimize the trauma inflicted.

The Recovery Planning Process

A recovery plan is a type of service plan or treatment plan that is developed in partnership with the person in recovery. It includes specific recovery-oriented goals chosen by the person on the recovery journey and it identifies personal strengths and resources which may be helpful in meeting the recovery goals. Comprehensive recovery plans should include goals for treatment, supports, transitions, and health maintenance. Individuals and providers should develop the goals and the plan together. The plan should guide services and be updated often. The plan should be put to practical use in setting goals and measuring progress toward wellness through all phases of care. A person should be able to choose components of the plan whenever possible. The recovery planning process should identify and use a person's strengths in designing a plan to overcome their difficulties. An individual should have enough information to make good decisions regarding his/her recovery plans.

Indicators:

- Recovery planning is collaboration between an individual and a service provider.
- Recovery plans are used continually to guide care and are updated regularly.
- Recovery plans are individualized and emphasize the person's strengths and choices.

Mental Health Advance Directives

Trained service providers should encourage and assist the development and instruction of mental health advance directives with the people that they serve. Whenever possible, Peer Support Specialists rather than providers should assist people with their mental health advance directives. A mental health advance directive is a document that indicates a person's wishes with regard to treatment in the event that the person is not able to make decisions about her/his own treatment. The document may also indicate a person or persons who are empowered to make decisions about the person in recovery's care, in the event that the individual is unable to do so. Mental health advance directives provide a way to respect the wishes of individuals should they become unable to make good decisions about their care in a crisis period of extreme illness. Service providers should give enough information to individuals so that they can make well-informed decisions. People should have opportunities to learn about and work on advance directives when they are in a reasonably good state of health.

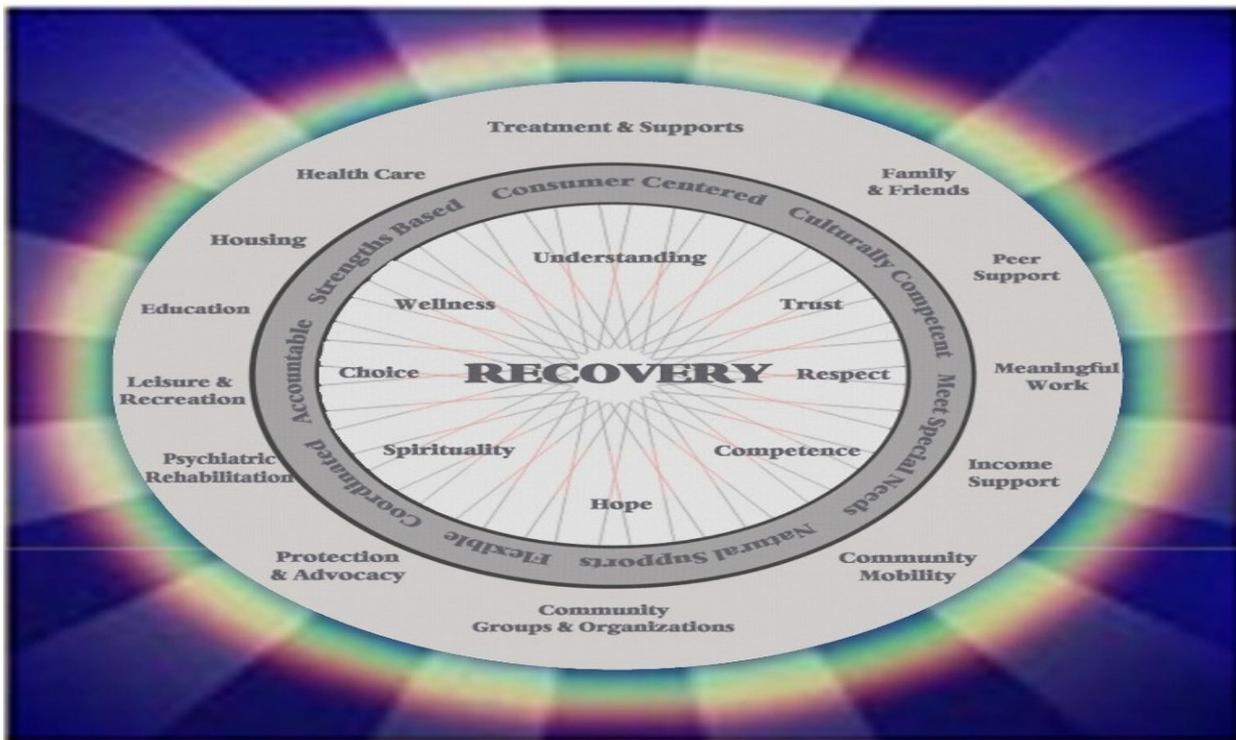
Indicators:

- Mental health advance directives and crisis plans are encouraged and respected by the organization.
- The service provider organization reviews advance directives during periods where the person has relapsed, is in a crisis, or is unable to make decisions about his/her own care.

III. Support Services

Some people may need a number of non-clinical or support services to aid in their recovery. Some support services are offered by behavioral health organizations, and some are available through other agencies or groups in the community. Service providers should help people to identify their community support needs and to facilitate access to appropriate support services.

COMMUNITY SUPPORT PROGRAM RECOVERY WHEEL



PENNSYLVANIA MENTAL HEALTH CONSUMERS ASSOCIATION
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Access to Community Support Services

Clinical service providers should assess the community support needs of persons who come to them for assistance. Providers should be familiar with available resources and assist the people in accessing appropriate community services and supports. Community support services may include transportation, housing, medical and dental services, child care, government benefits, peer support, employment services, educational programs, and financial resources.

Indicators:

- The community support needs of persons in recovery are assessed and documented.
- Those who coordinate or provide services help people to learn about and use available community resources.
- Community service plans are comprehensive and integrated into clinical service plans that emphasize and expand the person's capacity for independence.

Work and Meaningful Activity

All people need meaning in their lives. People in recovery who receive mental health and/or addiction services should have access to a wide range of training, education, employment, and volunteer opportunities. Providers should support involvement in work, volunteer, training, formal education, and other productive activities. Providers should facilitate referrals or interventions that allow people to advance their careers through higher education or specific career training. Training and supported employment should be integrated with other services.

Indicators:

- People in recovery have a wide range of work and volunteer opportunities with various levels of support for these activities.
- Individuals feel supported in their vocational choices and assisted in their pursuit of employment or education.
- Significant resources are set aside for helping persons in recovery to achieve their employment goals.

Health Literacy Education

A basic element of recovery is an individual's personal growth. A desirable outcome of recovery-oriented services is engaging people in formal and informal educational opportunities. Recovery-oriented services should provide many ways for learning about managing unpleasant or distressing symptoms, recovery and wellness, community services, and opportunities for personal growth and development. The recovery-oriented service should help people access and use information in a variety of formats. Service providers should support people in their informal and formal educational efforts.

Indicators:

- Ongoing opportunities to learn about recovery, wellness, symptom reduction, and services are available to all who receive services.
- Supports in pursuing and obtaining formal and informal educational goals and opportunities are made available to all persons.
- Service plans reflect attention to personal growth.

Community Involvement

Full inclusion in a community is an important element of recovery and personal choice is a standard of community mental health services and a major goal of all recovery-oriented services. This includes both their chosen residential community as well as spiritual, vocational, social, political, and recreational communities. Involvement in such communities provides a person with many satisfying experiences and access to a wealth of natural supports. Professional services should assist persons in choosing and gaining access to such communities while they assist persons in gaining the needed skills and supports to be successfully engaged with their chosen communities.

Indicators:

- Services help people in their recovery journeys learn about and participate in a wide range of opportunities for positive and meaningful involvement in various community roles.
- People are recognized for their meaningful involvement in various communities that are made available to them within and external to the community mental health organization where they receive services.
- Persons in recovery are encouraged to expand the networks of social connections within their own communities.

Family, Friends, and Significant Others Support

People recovering from behavioral health challenges often credit the support of friends, family and significant others as a key component of recovery. This support has two elements in recovery-oriented services. The first is the support *given* by friends, family and significant others to those in recovery. The second is the support needed *by* friends and family of people with significant emotional or cognitive difficulties. Family support can be a critical element in the successful recovery of those seeking wellness and healing. However, friends, family and significant others may have experienced considerable emotional, economic, and possibly physical disruption (e.g. children in Children Youth and Families, parent incarceration, etc.) during the illness/addiction of loved ones and require education and support themselves.

Indicators:

- Persons in recovery are encouraged to identify natural supports and in maintaining relationships as desired with family, friends and significant others.
- A wide range of educational opportunities are available to friends, family, and significant others of people in recovery.
- Friends, family, and significant others have the opportunity to participate in the behavioral health organization's process with the consent of the person in recovery.
- Community mental health organizations facilitate the participation of family/significant others in mutual support activities whenever that is desired by both the family, significant other and the person in recovery.

Peer Support

Peer Support involves a range of activities and arrangements in which those in recovery share information and supportive activities with one another. Peer support, also called mutual support, has had a long history of success in the addictions field. There is growing evidence of its importance and success in the behavioral health recovery field as well. Recovery-oriented services should maximize the ways that persons in recovery can have the opportunity to benefit from peer support.

Indicators:

- A wide range of opportunities for peer support within and outside the mental health organization are provided.

- Persons with lived-experience of serious mental illness and recovery are recruited, hired, and trained for a variety of positions within the mental health organization.
- Peer Support and Recovery Professionals are compensated at reasonable and respectful rates mindful of their training and continuing education requirements.
- Peer Support and Recovery staff is involved in the treatment of those they serve by participating as full members of the clinical team as paraprofessionals.

Housing

A wide range of independent living and supported housing options should be available to persons in recovery. Community providers should support individual preferences regarding their living situations whenever at all possible. Housing that makes few demands of residents should be available, including housing that is tolerant of substance use and does not depend on participation in services.

Indicators:

- People in recovery express satisfaction with available housing options.
- Individual preferences are respected and accommodated to the greatest extent possible.
- A full range of housing options are available including various tolerant housing options.
- All housing options support expanding independence and choice.

IV. Prevention

The World Health Organization reports that by the year 2020, behavioral health disorders will exceed all physical health diseases as a major international cause of disability. Recovery-oriented services and providers should continue to utilize evidence-based practices, early interventions, health education and promote physical health and behavioral health integration. These various resources help people access treatment earlier, mitigate symptoms and focus more on their recovery. The figure below displays eight different dimensions of wellness that are currently being promoted to provide a more holistic recovery approach.



Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal*, 29,(4) 311- 314.

Health Promotion

Recovery-oriented services provide education to persons in recovery and community organizations related to health maintenance. Health management programs are in place to assist individuals in making healthy choices about diet, exercise, medication, stress reduction, substance use and other aspects of their lives.

Indicators

- Health management groups are in place and engage community members.
- Health counseling is incorporated into all clinic appointments.
- Nutrition, exercise, substance use, and stress reduction information are available to clients and community members.
- Consultation and training is provided to community organizations wishing to promote health.

Risk Screening

Identification of individuals at risk for emotional disturbance, mental illness, substance use and medical conditions will allow opportunities to provide assistance early and avoid the severe disruptions and stress associated with these difficulties. Educational institutions, religious communities, primary care centers, and community organizations may provide opportunities to conduct screening activities. Recovery- Oriented Services may provide consultation and planning assistance to agencies developing screening processes. Adult service providers should offer screening for mental health and substance abuse issues for the children/adolescents of persons in recovery.

Indicators:

- A screening network involving educational programs, child care centers, primary care offices, community centers, religious centers, etc., is in place.
- Community education programs related to the purpose of the risk screening and the nature of mental health disruptions has been developed.
- Providers offer consultation, training and support for risk screening activities in the community.

Collaboration with Primary Care Providers

Ideally, services for behavioral health and physical health issues should be fully integrated (e.g. provided in the same location by clinicians that are part of an individual's treatment team). When this is not possible, service providers should establish opportunities for open lines of communication between behavioral and physical health providers. Care should be well coordinated and medical records shared easily (with client's consent) to facilitate this objective.

- Evidence of integration of behavioral health and physical health is present in the service planning process.
- Opportunities for communication between behavioral health and physical health care providers are available, promoted, and used.
- Service coordination is achieved through appropriate staffing and access to medical records.

Early Intervention

Recovery-oriented services refer to early intervention programs that include activities such as family education, health management skills training, support groups, parenting classes, and anger management programs. Candidates for these programs are identified through screening of the provider agency, community organizations, and primary care partners.

Indicators:

- System has access to full range of early intervention services for individuals, their children, and families.
- Education programs and support are available and easily accessible.
- Individuals report satisfaction with screening and referral processes.

Family Services

Recovery-oriented services will help identify distressed families and provide referrals to those families before they are in crisis. Referral resources might include family to family (peer) support groups, family education programs, family mentorship programs, families in recovery groups, and access to family recovery planning resources (family therapy, multiple family groups, etc.) Many of these services will be provided by voluntary community institutions such as religious communities, community service organizations, and parent-teacher associations in consultation with and encouragement from the provider community.

Indicators:

- Individuals and their families can easily identify resources available to meet their needs.
- Service providers consult with local family support centers and other community resources to provide safe, welcoming environments for families and their children.
- Links with community agencies that are able to provide supports are in place and collaborative interaction is established.
- Resources and services are available to families without an identified (diagnosed) person in recovery.

Protective Services

A safe environment for recovery occurs when there is an awareness of the potential presence of violence and sensitivity to its impact on individuals and communities. Recovery-oriented services will partner with and collaborate with protective services i.e., Child and Family protective services, law enforcement, corrections, domestic violence shelters, youth programs) to identify persons at risk.

Indicators:

- Full range of supportive family services is available and accessible.
- Protective services work toward reunification whenever possible and provide families with resources needed to resume custody.
- Adequate provisions are made for the safety of children.
- Victim support services are available and used appropriately.
- Trauma informed care is evident in clinical interactions.
- “Safe” Shelters are in place to meet the needs of those who are threatened.

Crisis Planning and Resolution

People under extreme stress (financial difficulties, deaths, tragedies and traumas) are often overwhelmed by the magnitude of demands placed upon them as they try to cope. Recovery-oriented services will maintain access and availability of crisis resources (i.e. warm/hot lines, peer counseling, grief and domestic violence support groups, safety shelters, legal aid, trauma debriefing, financial assistance, and coping skill building). They will do so by assessing needs in the community, establishing a referral network, and ensuring that individual crisis plans are in place. Consultation and training for community groups can develop as aspects of these programs. Providers encourage individuals to develop and have some form of crisis plan in place.

Indicators:

- Crisis plans are encouraged and respected by the organization.
- Crisis plans are incorporated in the overall recovery, wellness or service plan for the service user.
- A full array of crisis resources is represented in the provider’s referral network.
- Collaborative and consultative relationships exist between the provider and community based crisis programs.

Health Promotion and Resource Development

The resilience of a community is related to the well-being of its individuals, families, and organizations and their level of awareness of health promoting practices. Recovery-oriented services will empower families to influence their own environments and communities and to develop personal resources for managing their own health and to support the efforts of others in the community to do so. They will likewise support the development of community resources (i.e., with religious organizations, schools, PTAs, cultural institutions) through consultation and education and in enhancing the community's capacity to assist members in need.

Indicators:

- Families are active in shaping their community's environment.
- Community members are knowledgeable about methods for managing health.
- Community based support is available to most residents.
- The organization is active in assisting communities to organize themselves to create healthy environments.
- Consultation and education are provided to community groups.

V. Conclusion

In conclusion, your comments and suggestions are always welcome. For more information please go to the Allegheny County Coalition for Recovery Website, www.coalitionforrecovery.org for additional copies or information about this document. ACCR welcomes your ideas and input related to this document.

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APPENDIX E-1: SPA (Single Point of Accountability) CONTRACT LANGUAGE FOR ALL OBH FUNDED AGENCIES

FY 2015-2016

1. Service Planning

- a. Knowledge of Service Planning Principles.** All staff should be familiar with the recovery/resiliency-oriented Service Planning Principles developed by the Allegheny County Coalition for Recovery (ACCR), Quality Committee. These principles are listed in Appendix A.
- b. Service Planning Brochure.** Service Planning Brochures developed by the ACCR Quality Committee should be available to consumers in waiting rooms, distributed in service planning meetings and in the initial packets when a person begins service with an agency. Additional brochures can be requested through the ACCR website: <http://www.coalitionforrecovery.org/>

- c. **Utilizing the Service Planning Principles.** Staff should utilize Service Planning Principles in developing Service Plans/Treatment Plans with the people they serve and their families.
- d. **Approved to Use Service Planning Code.** Outpatient Clinics will be approved for the use of the Service Planning Code for Outpatient Therapists and Psychiatrists by 4/30/11.
- e. **Service Coordinator as Convener/Facilitator Included in Service Planning.** Agencies should allow access and encourage Service Coordinators to join in on service planning meetings. This expectation will grow incrementally each year.
- f. **Service Plans Approval.** Service Plans/Treatment Plans are to be approved / signed by Service Coordinators within/across providers if there are other agencies involved and if a Service Coordinator is assigned to the consumer.
- g. **Consumer Invited to Service Planning Meetings.** Adults – Service Recipients, as well as friends/family members upon consumer’s request, will be increasingly invited to attend Service Planning meetings. Children – Family members are included in the vast majority of Service Planning meetings.
- h. **Percent of Consumers Involved in Service Planning Meetings.** In Fiscal Year 14/15, at least 30 percent of the individuals served should have Service Planning involving the Service Coordinator as convener and facilitator and with the consumer present
- i. **Service Plans/Treatment Plans Shared with Service Coordinator** to better coordinate services across programs and agencies. This must be done with a valid release of information and the full knowledge of the consumer/parent(s) (if the consumer is a child).

2. **Single Point of Accountability Role of Service Coordination is communicated to Staff.** All agency staff are educated on the role of Service Coordination, it’s authority, functions and needs. Additionally, they are aware that respect and mutual cooperation is expected.

3. **Assessments**

- a. **Assessment Information Shared.** Information obtained from the consumer, family members and others as part of an assessment process will be shared with other programs providing support/treatment, if a valid consent to release information has been obtained.

- b. **Results from Needs/Strengths Assessment Tool.** Results from needs /strengths assessment tools will be shared with/by the Service Coordinator to avoid duplication of effort and asking the same questions within a short period of time.

4. **Service Coordination**

Therapists, psychiatrists, psychiatric rehabilitation/social rehabilitation staff and other staff will:

- a. **Use Service Coordinator as the Central Coordinator.** Utilize the Service Coordinator as the central coordinating staff on behalf of the consumer. Make sure that the Service Coordinator is kept up to date with any significant changes: address, diagnosis, needs, employment, etc,
- b. **Obtain Releases of Information.** Releases of Information to the Service Coordinator, if that Service Coordinator is employed by another agency, will be sought from the consumer and family members so as to coordinate services with the Service Coordinator.
- c. **Invite Service Coordinators to Service Planning Meetings.** The Service Coordinator will be asked to attend service-planning meetings with the consumer to discuss critical coordination issues with adequate notice.
- d. **Transitions from Higher Level of Care to Lower Level of Care –** The Service Coordinator, consumer and family members will be asked to attend staffing’s involving a change from a higher, acute level of care down to a less intense level of care.
- e. **Transitions from a Lower Level of Care to a Higher Level of Care -** The Service Coordinator, consumer and family members will be asked to attend staffing’s involving a change from a lower level of care up to a higher, more intense level of care.
- f. **Young Adult Transition Planning –** The Service Coordinator, consumer and family members should be invited and asked to facilitate or co-facilitate service planning meetings for adolescents who are expected to be using adult behavioral health services. These planning meetings should begin to occur between the ages of 14 and 16.
- g. **Utilize Service Coordinator in your service delivery.** The Service Coordinator assists in service planning, links to other services, brings more natural supports into the array of services. Actively use the Service Coordinator as a member of a treatment team, even if the team goes across agencies.
- h. **Involve Service Coordinator in critical decisions** as the Single Point of Accountability in the county.

- i. **Service Coordinators Gaining Access to the Consumer in 24 Hour Care.** Service Coordinators should be able to meet with consumers in inpatient, residential treatment, group homes or foster homes. Appropriate policies and procedures should be in place empowering agency staff to allow Service Coordinators to meet and talk with the consumers that they serve. This would include during the evenings and weekends. At the same time, Service Coordinators are expected to respect the services being provided and not interrupt critical clinical services. The Service Coordinator and the agency supervisory staff will determine how these meetings occur.
- j. **Invite other program/agency representatives to staffing's.** Agencies are to increase coordination across services (including employment, housing, and rehabilitation services) by inviting representatives from other programs/agencies who have significant involvement in the consumer's care and support.
- k. **Service Coordinators involved in Service Plan Reviews.** Service Coordinators have an additional responsibility to re-evaluate the needs and strengths, evaluate the Service Plan/Treatment Plan with the consumer, and assure that all programs are following through with the Service Plan/Treatment Plan objectives. Sometimes it may be unrealistic, given the volume of people served, to have the consumer and Service Coordinator in every Service Plan Review meeting. When it is not possible for the Service Coordinator to be present, other coordination methods should be employed with the Service Coordinator and/or consumer:
 - i. involvement by phone during the meeting,
 - ii. utilizing tele-health technology, or
 - iii. phone calls before and after the service planning meeting

5. **Complaints Procedure.** Agencies are to have policies and procedures in place for addressing consumer dissatisfaction/complaints, including a stakeholder review committee. The stakeholder review committee made up of staff, consumers and family members will review trends of complaints and resolution.

The county utilizes monitoring tools by which providers are held accountable consistent with these contractual expectations. Providers who do not meet the contractual expectations after several monitoring visits may experience paybacks or a period of probation (including a freeze of new referrals) until expectations are met.

APPENDIX E-2: SPA CONTRACT LANGUAGE FOR SERVICE COORDINATION PROGRAMS

FY 2015-2016

Allegheny County utilizes a Blended Service Coordination model which allows consumers to move through the recovery process with the support of one consistent Service Coordinator. Contact should be based on consumer need, but must meet the following **minimum** requirements: (1) **Adults** – monthly contact, with documented face-to-face contact occurring every other month; (2) **Children/Adolescents** – monthly face-to-face contact. Due to the intensity of caseloads changing as consumer needs change, the maximum caseload size is 30 for Adult Service Coordinators and 25 for Child/Adolescent Service Coordinators. Supervisors may supervise a maximum 9 Service Coordinators.

The exception to these regulations would be for Discharge Planning Service Coordinators. This level of support is available as an option for adult consumers identified with SPMI/SED who need additional time to transition out of Blended Service Coordination services. Discharge Planning Service Coordinators may have a maximum caseload size of 75. Minimum contact is monthly phone contact, with face-to-face contact occurring as indicated by the needs of the consumers. The average timeframe for this level of support is 1 year.

For fiscal year 2014/2015, it is expected that service coordination providers will complete the following preparation activities for the Single Point of Accountability:

1. **Training Policies and Procedures.** Development of Policies and Procedures to address the training needs for the new expectations of the Service Coordinators. The policies should reflect the commitment of the agency to assure that all Service Coordinators and Supervisors receive and are able to demonstrate competencies in areas outlined by the SPA Training Curriculum.
 - Five Day New Hire Training. All new hires since 2/1/2010 are currently required to attend and pass the post competency test for the five day training with a minimum score of 75%. This training is to be completed within three months of hire dependent upon availability of the training. If the proficiency is lower, the agency may choose to: (1) have SC repeat specific modules to increase their knowledge and retest, (2) increase supervision in the specific areas of concern, or (3) require additional mentoring. **The state-mandated WPIC OERP on-line training must be completed by existing Service Coordinators every two years, following completion of the initial New Hire Training.**

2. **Contingency Procedure**. Development of policies and procedures around the uses of contingency funds. These policies should include provisions to provide funds to consumers for food, clothing and shelter on an emergency basis but should also allow for the use of these funds to support recovery-focused activities that are contained in the service plan of the individual. The Service Coordinator should be thinking beyond the initial emergency and use funds to solve the future potential crises if possible. This may include Family Support Funds (children), Unified and Service Coordination Contingency Funds. An agency should be tracking the use of “natural supports” or other monetary funds/non-monetary resources used to support the individual/family. It is the expectation that \$1125.00 per Service Coordinator per agency will be allocated to this fund in Fiscal Year 14/15. Agencies will need to provide the County Monitor with the combination of Contingency Funds and all other monetary/non-monetary resources used in the Fiscal Year 14/15. Contingency Policy can be found on the SPA web page www.alleghenycounty.us/dhs/spa

Amount of Target - \$1,125 per Service Coordinator

We recommend that \$1,125 be budgeted each year for every Blended Service Coordinator and Adult Administrative Service Coordinator for FY 14/15. Children’s Administrative Service Coordinators are to be excluded from the calculation as we theorized their utilization is more related to FSS funds, which we decided not to incorporate in these changes. The contingency funds are to include those funds that historically been called: contingency and unified. Some agencies segregate contingency funds in different accounts. This should remain the discretion of the agency.

Minimum Target – A Target Floor

This target is a minimum floor. No agency can budget less than this amount and is expected to utilize the majority of those funds. Agencies can choose to budget and utilize larger amounts of Contingency Funds.

Training

All Service Coordinators need to be trained about resources, how to advocate for and obtain financial resources, and the appropriate use of Contingency funds when nothing else is available.

Expectations & Assumptions that should drive the request and approval of Contingency Funds

- **Avoid creating a dependency on the system** – When used for emergencies, funds should be used to resolve the initial crisis. Service

Coordinators should then work with consumers to implement skills and strategies to avert future financial crises.

- **Types of Contingency Funds utilization** - Shelter, food, utilities, medical, and clothes. Additionally, expenses to promote wellness, to start new healthy routines (YMCA membership, exercise class, exercise equipment).
- **Contingency Funds should be a last resort** - All other financial resources should be exhausted first.
- **Prevention of Future Crisis** - Funds should be used to avert future crises, helping to build in the consumer the capacity to avoid homelessness, recurrent admissions, or lack of food. Funds are to be used to develop a greater capacity of independence and not just resolve the immediate crisis.
- **Pay Back of Contingency Funds** - Most consumers are expected to pay back into the agency contingency fund, teaching financial responsibility and the need to live within a budget. This also is a better utilization of public mental health funds. Agencies should develop systems for tracking and collecting payments.
- **Utilization of Contingency Funds is to avoid deeper penetration into the system.**
- **Approval needs to be done by program management staff, not fiscal**
- Fiscal oversight watches for budget not being overspent and there is the appropriate documentation/receipts/rationale description.
- **County Monitoring** - County staff will monitor the amounts of Contingency Funds that are budgeted and utilized. The staff will also review the nature of what the Contingency Funds are utilized for to assure the funds are spent consistent with the expectations mentioned above.
- If agencies demonstrate a pattern of under-budgeting or under-utilizing Contingency Funds, or using the funds for uses beyond the expectation listed above, they will be at danger of losing the ability to accept new referrals and ultimately the ability to provide Service Coordination services.

3. Recruitment and Retention:

- a. **Job Description/Performance Evaluations** Agencies should write SPA responsibilities into agency job descriptions for Service Coordinators and into Performance Evaluation format.
- b. **Consumers Involved in Hiring** Involving adult and older adolescent consumers, family members, and other peer supports in the hiring process to help screen applicants is encouraged. Evidence would include a procedure that describes the hiring process and how consumers are involved. Further evidence would include documentation of various methods of consumer involvement.
- c. **Competency Based Hiring** Agencies should implement competency-based hiring reflective of the characteristics of highly effective Service Coordinators.
- d. **Career Ladder** Agencies should create a career ladder for Service Coordinators to assist in retaining staff in Service Coordination programs:
 - i. Training Mentors for new Children's staff which may include either a children's Service Coordinator or a children's Service Coordination Supervisor. --1/1/11
 - ii. Mentors for Adult staff which should include one mentor per team (supervisor) by 6/30/11 contingent upon availability of the Mentor Certificate Course.
 - iii. Sr. service coordinators paid higher salaries to provide consultation to other staff -- 7/1/11
 - iv. Other disciplines/expertise should be brought into Service Coordination teams, or agencies should develop strong coordinated treatment teams across agency programs (nursing, substance abuse, housing, seniors/elderly, employment and intellectual disability/developmental disability services) --7/1/13
- e. **Base Salary Floor** Increase salaries of Service Coordinators incrementally over the next 5 years contingent on parallel rate increases. As of 7/1/12 the Base salary for Service Coordinators must equal or exceed \$32,000.

4. Implementation of SPA within Service Coordination programs -- Development of Policies and procedures to address the following:

- a. **Consequences for Poor Staff Performance.** Agency program policies and procedures should define consequences/agency responsibility to address staff performance issues, in particular the ten affirmative Single Point of Accountability expectations.

- b. **Methods of Re-mediating Poor Staff Performance.** Agencies should develop consistent practices for advising, providing remedial training and disciplining Service Coordinators who consistently are unable to meet the accountability standards
- c. **Supervisory Responsibility.** The Supervisor of Service Coordination is responsible for oversight of the SPA expectations and to assure that all staff is fulfilling these expectations. Service Coordination supervisory job descriptions should reflect this supervisory duty. Job Descriptions and Supervision Logs will be reviewed by the County Monitor.
- d. **Improvement Goals.** Agencies/supervisors will set performance improvement goals for staff and teams. Programs will demonstrate a commitment to quality improvement, and provide evidence and outcomes of quality improvement plans/action plans from previous monitoring visits.
- e. **Crisis/Safety Plans.** Overall, the community safety net has fail-safe measures built in to assure that consumers get the services they need. There is a crisis plan driven by the consumer with the assistance of the Service Coordinator. The consumer is aware of crisis and emergency resources in their community and natural supports that can assist them.
- f. **MH Advance Directives (Adults Only).** Development of Mental Health Advance Directives is encouraged. At least 20% of the Adult consumer charts reviewed should show evidence that Advance Directives have been developed, or have at least been discussed, with consumers. County Monitors will review Progress Notes from past six months to see discussion of Advance Directives. County Monitors will look to see what each agency has done to make the system capable to perform this and what preparations have to be made to assist staff.

5. **Collaboration with the Larger System** As we move forward with this implementation, the greater system will utilize Service Coordinators differently. Agencies should develop a process whereby the environment that the Service Coordinators are working in is supportive of these new expectations. This environment should reflect the following:

- a. **Advocacy.** Service Coordinators are empowered within the agency and across agencies, as reinforced by the County / CCBH / AHCI, to be advocates for the client and for systemic changes.
- b. **Involvement with other Services.** Service Coordinators are involved in appointments with psychiatrists and therapists *with the consumers consent* particularly around assessment, planning, re-evaluation and coordination issues.

- c. **Active Liaison with Justice System.** Service Coordinators work collaboratively with the justice system including Children & Youth, Probation, County Jail, Justice Related Service, etc.
- d. **Active Collaboration with Health System.** Service Coordinators work collaboratively with medical providers
- e. **Active Collaboration with Community.** Service Coordinators work collaboratively with other systems, providers and resources (e.g., landlords, employers, educational institutions, places of worship, neighbors, sports or other leisure activities, special interests such as hobbies that take place outside of behavioral health systems and take place instead in the community of the consumer's choice, etc.)
- f. **Service Plans Approval.** Service plans are to be approved/signed by Service Coordinators within/across providers if there are other agencies involved – FY 14/15
- g. **Updates from other BH Programs.** Service Coordinators will request routine, updated information from other members of the treatment team. Evidence of collaboration will be documented in Service Plan Reviews and/or Progress Notes.

6. **Peer Services (Adults Only)** Develop policies to plan for Peer Specialist/Peer Support to enhance Service Coordination for adult consumers.

7. **Service Planning**

- a. Agency will be approved for the Service Planning Code for Outpatient Therapist and Psychiatrists by 4/30/11
- b. 30% of program caseload has undergone the Service Planning process with Service Coordinators acting as convener/facilitator with the consumer present and with other program representatives and friends/family members at the consumer's request. The Service Plan is signed by other treatment providers as identified in the Service Plan. County Monitors will request a list of service participants that have undergone service planning meetings and will cross-reference this information with service participant's Service Plans and/or other supporting documentation. Monitors will compare list to total program caseload to determine percentages.
- c. Supervision Logs/Notes will reflect that service planning is occurring with all Service Coordinators. Within the Supervision Notes, there will be notation as to whether these service planning meetings are pro-active vs. reactive in nature.

8. Affirmative SPA Responsibilities Committed to Procedure Agencies will build the Single Point of Accountability expectations into the Service Coordination program policies and procedures manual.

- a. Be the “go-to” resource for the person served and their family.
- b. Assure that there are effective “safety net” resources for the persons served.
- c. Clearly communicate to the person what they can expect from the system and what the system will expect of them.
- d. Assure there is periodic assessment & cross system planning to meet their needs while utilizing their strengths.
- e. Prepare for, convene/facilitate service planning meetings and provide follow-up after meetings.
- f. Assure there is cross system coordination of services and that services are being provided.
- g. Develop relationships that endure with persistent outreach even when there is reluctance to receive services.
- h. Assist the person served in developing and using natural supports.
- i. Be a persistent advocate for those served and give feedback on systemic problems.
- j. Provide a consistent positive outlook which encourages recovery and full inclusion in the community.

9. Supervision is provided in the community.

- a. Supervisors will observe and provide supervision in the community at least quarterly for each Service Coordinator.
- b. Mentors will provide monthly field-based mentoring for the first six months of employment for new hires. Supervisors will not have to provide field supervision during that first six months.
- c. Supervision Logs should note where supervision occurred (community or office setting).

The county utilizes monitoring tools by which providers are held accountable consistent with these contractual expectations. Providers who do not meet the contractual expectations after several monitoring visits may experience paybacks or a period of probation (including a freeze of referrals) until expectations are met.

APPENDIX E-3: SPA Contract Language for Specialty Service Coordination Programs

FY 2015-2016

For fiscal year 14/15 it is expected that Service Coordination providers will complete the following preparation activities for the Single Point of Accountability:

1. **Training Policies and Procedures:** Development of Policies and Procedures to address the training needs for the new expectations of the Service Coordinators. The policies should reflect the commitment of the agency to assure that all Service Coordinators and Supervisors receive and are able to demonstrate competencies in areas outlined by the SPA Training Curriculum.

Five Day New Hire Training. All new hires since 2/1/2010 are currently required to attend and pass the post competency test for the five day training with a minimum score of 75%. This training is to be completed within three months of hire dependent upon availability of the training. If the proficiency is lower, the agency may choose to: (1) have SC repeat specific modules to increase their knowledge and retest, (2) increase supervision in the specific areas of concern, or (3) require additional mentoring. **The state-mandated WPIC OERP on-line training must be completed by existing Service Coordinators every two years, following completion of the initial New Hire Training.**

2. **Contingency Procedure:** Development of policies and procedures around the uses of contingency funds. These policies should include provisions to provide funds to consumers for food, clothing and shelter on an emergency basis but should also allow for the use of these funds to support recovery-focused activities that are contained in the service plan of the individual. The Service Coordinator should be thinking beyond the initial emergency and use funds to solve the future potential crises if possible. This may include Family Support Funds (children), Unified and Service Coordination Contingency Funds. An agency should be tracking the use of “natural supports” or other monetary funds/non-monetary resources used to support the individual/family. It is the expectation that \$1125.00 per Service Coordinator per agency will be allocated to this fund in Fiscal Year 14/15. Agencies will need to provide the County Monitor with the combination of Contingency Funds and all other monetary/non-monetary resources used in the Fiscal Year 14/15. Contingency Policy can be found on the SPA web page www.alleghenycounty.us/dhs/spa

Amount of Target - \$1,125 per Service Coordinator

We recommend that \$1,125 be budgeted each year for every Blended Service Coordinator and Adult Administrative Service Coordinator for FY 14/15. Children's Administrative Service Coordinators are to be excluded from the calculation as we theorized their utilization is more related to FSS funds, which we decided not to incorporate in these changes. The contingency funds are to include those funds that historically been called: contingency and unified. Some agencies segregate contingency funds in different accounts. This should remain the discretion of the agency.

Minimum Target – A Target Floor

This target is a minimum floor. No agency can budget less than this amount and is expected to utilize the majority of those funds. Agencies can choose to budget and utilize larger amounts of Contingency Funds.

Training

All Service Coordinators need to be trained about resources, how to advocate for and obtain financial resources, and the appropriate use of Contingency funds when nothing else is available.

Expectations & Assumptions that should drive the request and approval of Contingency Funds

- **Avoid creating a dependency on the system** – When used for emergencies, funds should be used to resolve the initial crisis. Service Coordinators should then work with consumers to implement skills and strategies to avert future financial crises.
- **Types of Contingency Funds utilization** - Shelter, food, utilities, medical, and clothes. Additionally, expenses to promote wellness, to start new healthy routines (YMCA membership, exercise class, exercise equipment).
- **Contingency Funds should be a last resort** - All other financial resources should be exhausted first.
- **Prevention of Future Crisis** - Funds should be used to avert future crises, helping to build in the consumer the capacity to avoid homelessness, recurrent admissions, or lack of food. Funds are to be used to develop a greater capacity of independence and not just resolve the immediate crisis.
- **Pay Back of Contingency Funds** - Most consumers are expected to pay back into the agency contingency fund, teaching financial

responsibility and the need to live within a budget. This also is a better utilization of public mental health funds. Agencies should develop systems for tracking and collecting payments.

- **Utilization of Contingency Funds is to avoid deeper penetration into the system.**
- **Approval needs to be done by program management staff, not fiscal**
- Fiscal oversight watches for budget not being overspent and there is the appropriate documentation/receipts/rationale description.
- **County Monitoring** - County staff will monitor the amounts of Contingency Funds that are budgeted and utilized. The staff will also review the nature of what the Contingency Funds are utilized for to assure the funds are spent consistent with the expectations mentioned above.
- If agencies demonstrate a pattern of under-budgeting or under-utilizing Contingency Funds, or using the funds for uses beyond the expectation listed above, they will be at danger of losing the ability to accept new referrals and ultimately the ability to provide Service Coordination services.

3. **Recruitment and Retention:**

- a. **Job Description/Performance Evaluations.** Agencies should write SPA responsibilities into agency job descriptions for Service Coordinators and into Performance Evaluation format.
- b. **Consumers Involved in Hiring.** Involving adult and older adolescent consumers, family members and other peer supports in the hiring process to help screen applicants is encouraged. Evidence would include a procedure that describes the hiring process and how consumers are involved. Further evidence would include documentation of various methods of consumer involvement.
- c. **Competency Based Hiring.** Agencies should implement competency based hiring reflective of characteristics of highly effective Service Coordinators.
- d. **Career Ladder.** Agencies should create a career ladder for Service Coordinators to assist in retaining staff in service coordination programs:
 - i. Training Mentors for new Children's staff which may include either a children's Service Coordinator or a children's Service Coordination Supervisor --1/1/11

- ii. Mentors for Adult staff which should include one mentor per team (supervisor) by 6/30/11 contingent upon availability of the Mentor Certificate Course.
 - iii. Sr. Service Coordinators paid higher salaries to provide consultation to other staff members – 7/1/10
 - iv. Other disciplines/expertise should be brought into Service Coordination teams, or agencies should develop strong coordinated treatment teams across agency programs (nursing, substance abuse, housing and employment) --7/1/13
- e. **Base Salary Floor.** Increase salaries of Service Coordinators incrementally over the next 5 years contingent on parallel rate increases. As of 7/1/12 the base salary for Service Coordinators must equal or exceed \$32,000.

4. **Implementation of SPA within Service Coordination Programs:** Development of Policies and procedures to address the following:

- a. **Consequences for Poor Staff Performance.** Agency program policies and procedures should define consequences/agency responsibility to address staff performance issues, in particular the ten affirmative Single Point of Accountability expectations.
- b. **Methods of Re-mediating Poor Staff Performance.** Agencies should develop consistent practices for advising, providing remedial training and disciplining Service Coordinators who consistently are unable to meet the accountability standards.
- c. **Supervisory Responsibility.** The Supervisor of Service Coordination is responsible for oversight of the SPA expectations and to assure that all staff is fulfilling these expectations. Service Coordination supervisory job descriptions should reflect this supervisory duty. Job Descriptions and Supervision Logs will be reviewed by County Monitor.
- d. **Improvement Goals.** Agencies/supervisors will set performance improvement goals for staff and teams. Programs will demonstrate a commitment to quality improvement, and provide evidence and outcomes of quality improvement plans/action plans from previous monitoring visits.
- e. **Crisis/Safety Plans.** Overall, the community safety net has fail-safe measures built in to assure that consumers get the services they need. There is a crisis plan driven by the consumer with the assistance of the Service Coordinator. The consumer is aware of crisis and emergency resources in their community and natural supports that can assist them.

- f. **MH Advance Directives (Adults Only).** Development of Mental Health Advance Directives is encouraged. At least 20% of the Adult consumer charts reviewed should show evidence that Advanced Directives have been developed, or have at least been discussed with consumers. County Monitors will review progress notes from the past six months to see discussion of Advance Directives. County Monitors will look to see what each agency has done to make the system capable to perform this and what preparations have been made to assist staff.

5. **Collaboration with the Larger System:** As we move forward with this implementation the greater system will utilize Service Coordinators differently. Agencies should develop a process whereby the environment that the Service Coordinators are working in is supportive of these new expectations. This environment should reflect the following:

- a. **Advocacy.** Service Coordinators are empowered within the agency and across agencies reinforced by the County / CCBH / AHCI to be advocates for the client and for systemic changes.
- b. **Involvement with other Services.** Service Coordinators are involved in appointments with psychiatrists and therapists *with the consumers consent* particularly around assessment, planning, re-evaluation and coordination issues.
- c. **Active Liaison with Justice System.** Service Coordinators work collaboratively with justice system including Children & Youth, Probation, County Jail, Justice Related Service, etc.
- d. **Active Collaboration with Health System.** Service Coordinators work collaboratively with medical providers.
- e. **Active Collaboration with Community.** Service Coordinators work collaboratively with other systems, providers and resources (e.g., landlords, employers, educational institutions, places of worship, neighbors, sports or other leisure activities, special interests such as hobbies that take place outside of behavioral health systems and take place instead in the community of the consumer's choice, etc.)
- f. **Service Plans Approval.** Service plans are to be approved/signed by Service Coordinators within/across providers if there are other agencies involved – FY 14/15
- g. **Updates from other BH Programs.** Service Coordinators will request routine, updated information from other members of the treatment team. Evidence of collaboration will be documented in Service Plan Reviews and/or Progress Notes.

6. **Peer Services (Adults Only)**: Develop policies to plan for Peer Specialist/Peer Support to enhance Service Coordination for adult consumers.
7. **Service Planning**:
 - a. Agency will be approved for the Service Planning Code for Outpatient Therapist and Psychiatrists by 4/30/11
 - b. 30% of program caseload has undergone the Service Planning process with Service Coordinators acting as convener/facilitator with the consumer present and with other program representatives and friends/family members at the consumer's request. The Service Plan is signed by other treatment providers as identified in the Service Plan. County Monitors will request a list of service participants that have undergone service planning meetings and will cross-reference this information with service participant's Service Plans and/or other supporting documentation. Monitors will compare list to total program caseload to determine percentages.
 - c. Supervision Logs/Notes will reflect that service planning is occurring with all Service Coordinators. Within the Supervision Notes, there will be notation as to whether these service planning meetings are pro-active vs. reactive in nature.
8. **Affirmative SPA Responsibilities Committed to Procedure**: Agencies will build in the accountability for the Single Point of Accountability expectations into the service coordination program policies and procedures manual.
 - a. Be the "go-to" resource for the person served and their family.
 - b. Assure that there are effective "safety net" resources for the persons served
 - c. Clearly communicate to the person what they can expect from the system and what the system will expect to them.
 - d. Assure there is periodic assessment & cross system planning to meet the needs while utilizing their strengths.
 - e. Prepare for, convene/facilitate service planning meetings and provide follow-up after meetings.
 - f. Assure there is cross system coordination of services and that services are being provided.
 - g. Develop relationships that endure with persistent outreach even when there is reluctance to receive services.
 - h. Assist the person served in developing and using natural supports.

- i. Be a persistent advocate for those serve and given feedback on systemic problems.
- j. Provide a consistent positive outlook which encourages recovery and full inclusion in the community.

9. Supervision is provided in the community:

- a. Supervisors will observe and provide supervision in the community at least quarterly for each Service Coordinator.
- b. Mentors will provide monthly field-based mentoring for the first six months of employment for new hires. Supervisors will not have to provide field supervision during that first six months.
- c. Supervision Logs should note where supervision occurred (community or office setting).

The county utilizes monitoring tools by which providers are held accountable consistent with these contractual expectations. Providers who do not meet the contractual expectations after several monitoring visits may experience paybacks or a period of probation (including a freeze of referrals) until expectations are met.

APPENDIX F-1: PA DHS/OMHSAS STUDENT ASSISTANCE PROGRAM GUIDELINES

Revised 8/1/05

Commonwealth of Pennsylvania Department of Human Services (PA DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) and Substance Abuse Services Student Assistance Program Minimum Guidelines For County Mental Health Programs and Liaison Services

Introduction

The Commonwealth Student Assistance Program (SAP) utilizes a systematic process involving a team composed of professionals from various disciplines within the school and liaisons from community agencies. These selected professionals are trained to identify non-academic barriers to learning and, in collaboration with families, to strategize for and/or refer identified students for assistance that will enhance their school success. As representatives of the community mental health system, professionally trained liaisons provide consultation to teams and families regarding the need for referral to community-based assessment for mental health problems.

The Guidelines for County Mental Health Programs and Liaison Services were originally developed in 1990 and revised in 1997 and 2002. The guidelines identify roles and

responsibilities for schools and the local mental health system involved in the operation of a successful Student Assistance Program to promote effective practices at the local level. Technical assistance for the implementation of these guidelines is available to individual counties/county-joiners and liaison service providers through PA Network for Student Assistance Program (PNSAS) regional coordinators and the Office of Mental Health and Substance Abuse Services (OMHSAS) and Substance Abuse Services (OMHSAS) field offices listed in the attachment to these guidelines.

Guidelines for County Mental Health/Mental Retardation (MH/MR) Program Administrators for the Implementation of Student Assistance Program Services

1. Contract with and monitor one or more local providers for effective delivery of SAP services to Student Assistance Program core teams in the county/ county-joiner as outlined in the guidelines for SAP liaison services.
2. The contract with the providers includes on-site consultation services to SAP teams within the individual county/county-joiner area. Schools without the essential elements of an effective SAP core team may be omitted from liaison services and reported to your PNSAS Regional Coordinator for possible monitoring. (See the MH SAP Guidelines Revised 8/1/05 2 “Student Assistance Program Guidelines for Schools and School Districts”, available on the SAP website www.sap.state.pa.us)
3. The contract will ensure that direction and supervision for the SAP liaison staff is provided by an individual who has training and is knowledgeable of SAP and is capable of providing a local system-wide focus supporting SAP.
4. In addition the contract will ensure that the SAP liaison service provider develops and adheres to the Letters of Agreement they have established between the agency and the school district that they serve.
5. County MH/MR Administrators will ensure a system for regular communication with all stakeholders for Student Assistance Programs at County SAP Coordination Team meetings and/or District Councils. Stakeholders include schools, community child serving systems, parents, students, and locally based SAP Commonwealth Approved Training Providers (CATS).
6. County MH/MR Administrators will provide information in the areas of local child serving system resources, how to access resources, and local treatment and continuity of care issues to CAT’s from SAP training occurring for schools in the county/county-joiner area.
7. County MH/MR Administrators will utilize state and county SAP and other relevant data to annually evaluate the efficacy of the local child-serving system with schools, contracted providers, and other stakeholders.

8. County MH/MR Administrators will work collaboratively and participate in a local conflict resolution plan for student assistance services. (See attached Conflict Resolution Process)
9. County MH/MR Administrators will submit reports as required by OMHSAS. Guidelines for SAP Liaison Services from the County/Joinder MH/MR System to SAP Core Teams

Agency Roles and Responsibilities

1. The contracted provider(s) will ensure appropriate agency personnel that supervise SAP liaisons is knowledgeable about SAP has training in the Student Assistance Program and is capable of providing a local system-wide focus and representation supporting SAP.
2. The contracted provider(s) staff whose role is to function as a liaison for more than one community service system, must have knowledge, skills, and appropriate supervision in each system.
3. Letter of Agreement should be negotiated and signed annually by administrators from the SAP Liaison provider and the school building or school district(s). The letter of Agreement to be implemented outlines the provision of services that will be provided to the school building/school district and what the agency can expect from the school building/district. A copy of these letters will be forwarded to the county/county joinder MH/MR Administrator.

Note: Where mandatory Medicaid Behavioral Health Managed Care program exists, Letters of Agreement with school districts will include the MA Managed Care program expectations for the county/county joinder.

4. Letters of Agreement will outline the following as applicable:
 - designated contact persons for the school and agency
 - the name of the liaison assigned to each core team
 - the frequency of attendance for liaisons at core team meetings
 - the role of the liaison in the school SAP process
 - referral for assessment procedures
 - consultation/education services
 - school and agency responsibilities and expectations
 - a list of services to be provided and their accompanying cost, if any, to the school
 - emergency crisis assistance/postvention procedures

- the relationship of all services provided by the agency to the SAP
 - record-keeping requirements
 - a procedure for conflict resolution
 - confidentiality procedures
5. Liaisons will receive and maintain student assistance program certification through training provided by a CAT. When schools develop new or additional teams, the liaisons assigned to the new or additional SAP team are encouraged to attend training with the school personnel as determined by the CAT.
6. Liaisons will have knowledge of:
- the local child-serving systems
 - child and adolescent mental health
 - procedures for accessing local resources for students and families
 - the school culture and the SAP-related school policies and procedures for the teams to which they are assigned
 - up-to-date information on Commonwealth school-based student assistance program policies, procedures, and related issues
 - their area of expertise for identification of intervention and treatment needs
 - crisis intervention/postvention procedures
 - suicide prevention and intervention
 - assessment procedures
7. Liaisons will have skills in:
- working with parents, students and school personnel
 - serving as advocates for parents/caregivers and students in the health care system
 - accessing local resources
 - consulting with school and community child-serving professionals
8. Responsibilities for liaisons assigned to SAP core teams include:
- attending core team meetings at least twice per month per team. (Attendance at additional core team meetings is desirable, as schedules permit.)
 - making provisions for consultation between site visits for teams to which they are assigned
 - serving as a member of the school core team as a consultant from their area of expertise

- consulting with teams for interventions and assisting parents in accessing the appropriate services for assessment of treatment needs
- participating in team maintenance and program evaluation activities with core team members
- providing in-service and program updates to teams on emerging SAP issues
- facilitating and supporting the school-based aftercare plan for students who are returning to school from treatment
- facilitating and/or assisting when requested with “postvention” efforts in the event of any tragic death including suicide of a student, teacher, or community member that would adversely affect the school community
- maintaining appropriate data as determined by the county/joinder to assist schools and county/joinder MH/MR Administrators in completing reports as required by funding sources

9. If resources are available and additional services are requested by schools, other appropriate roles for liaisons could include:

- liaison services to Elementary Student Assistance Teams
- assisting the school with stakeholder in-service (i.e., school board, parents, school staff, community members, etc.)
- facilitating team maintenance for teams for whom they are not members
- co-facilitating student education and intervention groups in school
- participating in interventions with students and parents
- helping to identify appropriate interventions and actions for students and families
- linking schools and/or families with community services for emergency crisis assistance when needed
- consulting with schools around strategies for engaging parents in the SAP process
- providing follow-up with parents and students through assessment and treatment
- providing technical assistance for policy development in areas related to their field of expertise for providers, the local child-serving systems, and school
- consulting with elementary school personnel regarding the needs of students and families for community-based service

- providing site-based student assessments for treatment and/or short-term treatment under the following conditions:
 - a. if liaison is professionally qualified,
 - b. if parental permission has been given,
 - c. if provided in the context of any existing requirements for prior authorization

Appendix F-2: STUDENT ASSISTANCE PROGRAM REPORTING PROCESS

Allegheny County Office of Behavioral Health Student Assistance Program Mental Health Providers Process:

1. Each liaison reports activities to management each month (or enters the data into their own copy of spreadsheet)
2. Information is compiled into the worksheet for the appropriate quarter.
3. Point person extracts that data from the quarterly spreadsheet –adding all of the building specific data together in the columns
4. Quarterly information is entered into the PDE system
5. Spreadsheet (with each quarter worksheet completed consecutively and included in the workbook) is emailed to county along with notice that online data has been entered and is awaiting approval
6. County representative will go into the site and examine the reports and approve or reject the report
7. At the end of the year June 30-each agency will submit completed spreadsheet with each quarterly worksheet completed
8. Site monitoring will take place July and August
9. Letters of agreement are to be submitted on or before October 15th.

Quarter 1	Reports are due October 15, 2015
Quarter 2	Reports are due January 15, 2016
Quarter 3	Reports are due April 15, 2016
Quarter 4	Reports are due July 15, 2016

APPENDIX G: CONSOLIDATED COMMUNITY REPORTING INITIATIVE (CCRI)

Community Reporting Initiative (CCRI) is to build the statewide data infrastructure necessary to report consumer-level service utilization and outcome information on persons receiving County base-funded mental health services.

OMHSAS is now required to provide consumer-level information on: persons served, services rendered, the associated costs, and consumer outcomes. The Substance Abuse and Mental Health Services Administration (SAMHSA) is now moving toward having states build the capacity to report on mental health treatment episodes.

All providers must adhere to the PA Department of Human Services' Office of Mental Health and Substance Abuse Services bulletin number OMHSAS-14-30 dated August 1, 2014. This bulletin can be found here:

http://www.DHS.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/c_093853.pdf

More information about CCRI can be found here: <http://164.156.57.44/myDHS/omhsas/reporting/index.htm>

Any questions related to CCRI can be directed to DHS-CCRI-Support@AlleghenyCounty.US

Appendix H: Incident Reporting Standards

Allegheny County Office of Behavioral Health

Incident Report Process: Each Service Coordination Unit is responsible for reporting an incident as outlined by the following standards:

1. Incident reports are to be submitted to the Office of Behavioral Health. Verbal reports are to be called into 412-350-4457 within 24 hours. Written reports are to be faxed to 412-350-4245 within 48 hours. Residential Providers are to report incidents via Home and community Services Information System (HCSIS)
2. Reportable incidents include but are not limited to death, suicide, suicide attempt, significant medication error, missing person, physical/sexual abuse and arrest.
3. If applicable, the county point person will distribute incident reports to the Community Integration Team or the Children/Adolescent Bureau for their review and follow-up.
4. The county point person for each unit reviews incident reports to assure they have been properly completed and follows up with the person making the report to assure that thorough investigation has been conducted by the provider and assure follow-up actions have been taken by the provider to protect the consumer and prevent reoccurrence of any incident.
5. The county point person for each unit follows-up on the reports with the person making the report and compiles a list of incidents into the Allegheny Health Choices (AHC) data base.
6. Each week the incidents are reviewed and analyzed by OBH and Community Care. If an incident is considered to be a sentinel event. A Root Cause analysis (RCA) is recommended. A sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof, unrelated to the natural course of an individual's illness or underlying condition.
7. For this process, the sentinel event will involve one or more persons who receive or have received mental health services from a contracted provider of the Allegheny County Department of Human Services or Community Care, or an event that impacts in a significant manner on the entire mental health system. OBH will work in collaboration with Community Care Behavioral Health (Community Care) to coordinate the completion of these RCAs by mental health service providers.
8. A review process takes place weekly with the county
9. The basic concept of a RCA is to conduct a detailed investigation of the circumstances of an event until the specific cause(s) and the relevant system cause(s) are identified. If at any time during the investigation, critical issues that require immediate intervention are discovered, such issues must be addressed as quickly as possible.

Ultimately, the goal of the RCA is to reduce risk and promote safety, and to arrive at recommendations on how to best prevent sentinel events from happening again.

Appendix I: Centralized Residential Referral Process

Allegheny County Office of Behavioral Health

Centralized Residential Referral Process: The Allegheny County Centralized Residential Referral Process is designed to manage the day-to-day activities of all incoming residential referrals for adults with serious mental illness who are in need of housing 24 hours/ 7 days a week as outlined by the following guidelines:

1. The referral source completes the residential referral form. The referral source

Selects Only one Level of Care from the list below.

- Comprehensive Mental Health Personal Care Home (CMHPCH)
- Long Term Structured Residence (LTSR)
- Community Residential Rehabilitation (CRR) – Apartment
- Community Residential Rehabilitation (CRR) -Group Home
- Mental Illness Substance Abuse (MISA CRR)-Group Home
- 24/7 Supportive Housing (SH)-24 hour staffed
- Specialized Residence (SR)-Small 3 person homes
- Personal Care Home (PCH) Senior Care Plaza 4th floor –(MYCS) Only
- Domiciliary Care (Dom Care) Community Human Services Only (CHS)

The Allegheny County Residential Referral form is to be completed in its entirety. Incomplete referrals will delay the process.

Once the referral has been completed it must be faxed or emailed to Allegheny County-Office of Behavioral Health(AC-OBH) at 412-350-4245 or obh-centralizedreferrals.us A completed referral packet must include the referral form and psycho-social history (included with referral). **For community referrals; physical, psychiatric evaluation, and TB test results are required at the time**

- 2. of the interview for any given residential program. For any referral being made from a hospital or extended acute care unit, the above items are to be included in the referral packet.** AC-OBH staff will review the referral to make sure that all information is provided. If needed, the referral source will be contacted to discuss any

questions and confirm the level of care being requested. The consumer's name will be placed on a residential waiting list held by AC-OBH for each identified Level of Care. (Only one Level of Care is Permitted per person)

3. HOW IS THE REFERRAL PROCESSED:

- **Within 3 business days** of the residential provider becoming aware of the pending vacancy, the residential provider must submit the residential Discharge/Vacancy Report to AC-OBH for review.
 - AC – OBH Staff will email or fax the referral of the next identified person to the residential provider who reported the vacancy. Preference is given to individuals who are on the priority list. This is usually determined at the AC-OBH weekly vacancy meeting.
 - The residential provider completes the residential referral response form and sends it back to AC-OBH. This is ongoing until the consumer is admitted into the program. This form provides updates on the consumer's status from intake to move in date.

- **Within three (3) business days** of the residential provider's receipt of the referral, the consumer is to be interviewed. If agreed, a tour and or interview shall be scheduled. The Residential program is required to provide an overview of the program and expectations for the consumer during the intake/interview.

- **Within 3 business days** from the date of the interview, a move in date shall be determined and reported to AC – OBH via the residential response form. If the Residential Program feels that the consumer does not meet the criteria for their program or has concerns of any kind about a referral this will need to be reported to **Emil Pyptyk** via email at emil.pyptyk@allegHENYcounty.us A treatment team meeting is to be scheduled by the residential provider to discuss the needs of the program to support the individual. This treatment team meeting should be convened as soon as issues are identified as another referral WILL NOT BE sent until a determination has been made. OBH Representative will be present as needed at these meetings.
 - Once the consumer has been admitted to a residential program, the referral is closed and the consumer's name is removed from the waiting list.
 - If the consumer is not admitted for any reason the referral source will determine within **(1) business day** if the person should remain on the waiting list. If AC-OBH does not hear from the referral source, the referral will be closed and the individual will be removed from the waiting list.

- When the person is discharged from a residential program all discharge/vacancy report is to be submitted to AC-OBH.

4. TRIAL VISITS

- Trial Visits are **NOT required** for admissions
- When it is determined that a trial visit will be necessary the standard trial visit will be 3 days. Additional days may be requested and negotiated individually with the referral source and residential provider.
- Residential staff shall assess the trial visit and discuss the admission process with the individual and referral source.
- A direct admission may occur on the final day of the trial visit or within three (3) business days following the trial visit. Exceptions may be negotiated and agreed upon between the referral source and residential provider.

5. PRIORITY LIST FOR PLACEMENT

The Office of Behavioral Health will make a determination as to which person will be given priority when there are multiple individuals vying for the same bed. Consumers will be given priority if they are currently:

- In a State Hospital (Torrance State Hospital)
- Torrance State Hospital/ Forensic Diversion
- On a Psychiatric Inpatient Unit with a County Disposition
- On TRU (Transitional Recovery Unit)- Located at WPIC
- On CRU (Comprehensive Recovery Unit)- Located at WPIC
- In an RTFA (Residential Treatment Facility for Adults)
- At the EAC (Extended Acute Care)
- Have a Community Support Plan (CSP) or Acute Community Support Plan (ACSP)
- Residing in an LTSR and ready for a lower level of care
- Transitional Age being discharged from RTF with CYF involvement

- Deaf and in need of American Sign Language (ASL) supportive services (*Leland Point & Threshold only*)

6. SECONDARY PRIORITY LEVEL

- On a psychiatric Inpatient Unit without a County Disposition
- Diversion And Acute Stabilization (DAS) Respite/ RTP
- Criminal Detention (jail)
- Referrals from other DHS offices

7. MANAGING THE WAITING LIST

- Each Month SCUs will receive a list of all their referred consumers. (distributed to the identified contact person)
- SCUs are to make updates to the waiting list. The report is to be faxed or emailed back to AC-OBH by the 15th of each month. AC-OBH will review the report and make updates s to the database.
- Referrals expire after one year. In the *Need New Referral Within 60 Days* column, note that the referral source will have 60 days prior to the expiration to complete the new referral. Expired referrals will be removed from the waiting list unless an updated referral is received in the AC-OBH prior to the expiration *date (1 year from the original referral date that the referral was received in the OBH office.*

Appendix J: Comprehensive Mental Health Personal Care Home (CMHPCH)

Allegheny County Office of Behavioral Health

CMHPCH: All Comprehensive Mental Health Personal Care Homes must be licensed and meet all the requirements of the personal care home regulations as well as the following standards.

1. STAFFING:

- a. At a minimum, there shall be at least two (2) staff on duty during the day and evening hours. Consideration should be given to the current consumer needs in the home in determining the need for additional staff.

- b. At all times, the staff to consumer ratio should be maintained at no more than 15 consumers per staff person.
- c. There must be at least 1 awake staff person at all times and a back-up plan for additional staff when necessary.
- d. All staff must have a bachelor's degree in the human service field or any combination of education and experience in the human service field, i.e.; associates degree and 2 years' experience or high school diploma and 4 years' experience.
- e. A minimum of one bachelor's level staff must be on site at all times.
- f. There should be a minimum of 2 staff that are mental health professionals that are also certified as Personal Care Home Administrators.
- g. There must be a plan for the availability of additional staff when needed based on the consumer's needs.
- h. There must be a full-time registered nurse on the staff if the home has 30 or more residents or a part-time registered nurse if the home has less than 30 residents.
- i. There must be a full-time Activities Director if the personal care home has 30 or more residents or if the home has less than 30 residents the Personal Care Home Administrator must assure that activities are planned and offered.
- j. There must be a minimum of 1.5 FTE qualified cook with a Food Handler's Certification for every 15 consumers and an additional .5 Ft.'s for every additional 5 consumers

2. TRAINING (TO EXCEED THE PCH REGULATIONS):

- a. Within 30 days of beginning to work at the Personal Care Home, each staff person must receive an orientation that includes the following:
 - b. Overview of Mental Illness
 - c. The consumer perspective
 - d. The family perspective
 - e. Psychotropic medications by a qualified instructor
 - f. Consumer rights
 - g. Confidentiality
 - h. Recovery model and philosophy

- i. Crisis Intervention (it is desirable that this training be offered within the initial 30 days but mandatory that it occur within the initial 60 days).
- j. There shall be a minimum of an additional 15 hours of training for each staff person annually.
- k. A training plan shall be developed for each staff person to ensure that topics listed below are covered either annually or every two- (2) years as noted below.
- l. Annual training shall include:
 - 1. OSHA
 - 2. Fire Safety
 - 3. Psychotropic medications by a qualified
 - 4. Instructor
 - 5. Crisis intervention
 - 6. Consumer rights
- m. Every two (2) years training shall include:
 - 1. CPR/First Aid (as required by the certification)
 - 2. Recovery Model and Philosophy
 - 3. MISA
 - 4. HIV/AIDS
 - 5. Behavior Management
 - 6. Mental Health Service System
 - 7. MR/DD
 - 8. Confidentiality
- n. Training is required for all staff working in the personal care home, including housekeeping, maintenance and kitchen staff
- o. Additional training opportunities should be offered and available to all staff based on the individuals training plan.
- p. A Food Handler's Certification is required for all staff working in or with access to the kitchen.

3. RESIDENT COUNCIL:

- a. There must be a written policy regarding the role and process for the Resident Council.
- b. There must be monthly consumer/resident directed meetings for the Resident Council.

- c. The written policy must define the process for recommendations to be submitted and reviewed by staff and for a written response from the personal care home administration back to the resident council.
- d. The Resident Council should have input into the dietary meal planning- including snacks, and both on-site and off-site activities offered.

4. MEDICATIONS:

- a. Medication monitoring by staff must be available.
- b. There must be policy and procedures for medication counts, quality control and medication storage.
- c. All medication policy and procedures should be developed or reviewed by appropriate medical staff----Psychiatric Nurse and Psychiatrist.

5. ACTIVITIES:

- a. Resident participation in activities is voluntary.
- b. The activity schedule and types of planned activities must be reviewed and input from the Resident Council.
- c. Onsite organized activities must be offered a minimum of once a day, seven days a week.
- d. Some onsite activities must be offered during the evening hours.
- e. An offsite activity must be offered a minimum of once a week---the type of activities offered must be developed with Resident Council input.
- f. There must be accessibility to a van for offsite activities. If one or more of the residents is mobility-impaired, there must coordination for handicapped-accessible transportation for offsite activities.
- g. There must be a minimum of one van per home.
- h. There must be documentation of all planned activities including attendance at the event.

6. PHYSICAL PLANT:

- a. The physical plant must meet the requirements of the Personal Care Home regulations.
- b. There must be single room occupancy.

- c. The personal care home must be accessible to public transportation.
- d. The personal care home must be handicapped accessible.
- e. A smoking room with appropriate exhaust system must be available for the residents.

7. LINKAGES AND REFERRALS:

- a. There shall be a PCP or House Doctor available for emergencies.
- b. There shall be appropriate linkages with a pharmacy for medications.
- c. There must be available and accessible appropriate treatment and rehabilitation options for the residents.
- d. There must be linkages for appropriate emergency and crisis services.
- e. There must be available linkages for appropriate vocational and educational options for the residents.
- f. Personal Care Home staff must be available to assist a resident in obtaining additional support and treatment services.
- g. There must be access to a registered dietician for special needs.

8. RECORDS MUST INCLUDE:

- a. Daily living skills assessment
- b. Daily progress note
- c. Emergency relocation plan

9. ADMISSION CRITERIA MUST INCLUDE:

- a. Services are voluntary
- b. Residents must be 18 years of age or older
- c. There must be documentation of a primary mental health diagnosis
- d. The admission criteria must meet the PCH regulations
- e. The admission criteria must document that the resident does not require a more or less restrictive setting.

10. DISCHARGE CRITERIA:

- a. VOLUNTARY DISCHARGE: There is no expected or required length of stay or any requirement/expectation that the resident must move to a different level of care within any length of time---this is not a rehabilitation program.
- b. INVOLUNTARY DISCHARGE:
- c. There must be a written process for eviction
- d. Eviction should only be considered when there is documentation of multiple or repetitive abuses and attempts to resolve or negotiate the issues has not been successful or if there is an immediate risk to the safety of the resident or others in the personal care home
- e. There must be written policy and procedures that includes the role of the Resident Council in reviewing all evictions.
- f. Written policy and procedures must require an interagency meeting and resident contract prior to any eviction
- g. There must be a written discharge plan for the resident developed in collaboration with the SCU or CTT
- h. There must be a written appeals process.

11. The personal spending allowance must be a minimum of \$150.00 per month for each resident.

12. Incident reporting is required.

13. PRIORITY FOR ADMISSIONS WILL INCLUDE:

- a. CHIPP discharges
- b. Other state hospital discharges from Mayview and Torrance State Hospitals
- c. Individuals who are ready to “step-down” from an LTSR
- d. Diversions from the state hospitals
- e. Forensic consumers
- f. Individuals who are homeless
- g. Other community referrals

14. There will be no standards set for size of the Personal Care Home or any requirements for a treatment or service plan for the residents.

As much as possible a no reject/no eject policy will be in place but resident safety considerations may require an eviction process. The eviction process must be specifically defined as noted above.

Appendix K: SERVICE COORDINATION

Allegheny County Office of Behavioral Health

Service Coordination: Adults with serious mental illness and children/adolescents with serious emotional problems who have difficulty functioning in their daily life and who need help finding services and supports that will assist them on their road to recovery.

1. Referrals for Service Coordination may come from a therapist, nurse, or psychiatrist. Individuals may also call one of the Service Coordination Units (SCU) directly.
2. A Universal Referral Form is completed and sent to a SCU. Only one referral is to be submitted per SCU for consideration.
3. Each SCU has their own way of processing referrals; however, it is expected that individuals be assigned within 7 days. If they cannot be assigned, the individual is to be offered the choice of waiting or being connected with another SCU that can provide SC services.
4. Once an individual has been assessed, a Service Coordinator is assigned to work with the individual on:
 - a. Assessing needs and strengths
 - b. Service planning to help navigate the available services and to find the right combination of supports
 - c. Linking to services/supports that are convenient, effective and that help bring about positive changes
 - d. Coordinating the services and supports to make sure they are working together
 - e. Evaluation/monitoring the different programs to ensure they are consistently working to help the individuals achieve their goals for recovery and that individual needs are being addressed.
 - f. Advocating on behalf of the adult/child to get the services they need while removing barriers and protecting their rights.

5. Discharge from Service Coordination: Since August 2008 the requirement has been that ALL closures and supporting documentation be sent to the County Office of Behavioral Health for final approval and signature before case closure. This requirement is now amended by eliminating the requirement for County signature and approval for cases where service has been performed by children's case managers. As of July 1, 2013 County signature and approval are required in the following circumstances for closures of **adult** cases:
 - i. Consumer disagrees with the closure/transfer
 - ii. Consumer is not available to sign the closure/discharge summary
 - iii. Consumer refuses to sign the closure/discharge Summary
 - iv. Provider has determined that there are significant reasons why the consumer should not be served in the program at the time
6. To assist process efficiency:
 - a. An email in place of a phone call may be sent to alert County Monitors of a pending closure.
 - b. A **certified** letter is no longer required when it is known that consumers are not available for signature. A letter via U.S. Postal mail is still required, however, to inform consumers of the closure and where assistance may be obtained if needed.
 - c. The time requirement for outreach effort to locate consumers has been reduced from 90 days to 45 days. Significant efforts must be made during this timeframe to locate the consumer.
 - d. The closure process will be reviewed during SCU monitoring. If the process is not appropriate or there has not been substantial effort to perform outreach, the provider's outreach policy will be reviewed for possible modification.
 - e. Closures that are sent to the County for signature and approval will also be reviewed with CCBH, if the person is a CCBH member.
 - f. If the consumer is being transferred to a higher level of care, the **maximum** crossover time period is 90 days. This timeframe may be shorter if all parties involved agree.
 - g. If you have any questions, please contact Regina Janov @ 412-350-3476 or Michael Szymborski @412-350-4954.