ALLEGHENY COUNTY

DEPARTMENT OF HUMAN SERVICES

CONTRACT SPECIFICATIONS MANUAL
FOR SERVICES PURCHASED FOR INDIVIDUALS OF
THE OFFICE OF BEHAVIORAL HEALTH
BUREAU OF MENTAL HEALTH

ADULT MENTAL HEALTH SERVICES AND
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

FY 2020-2021

The Allegheny County Department of Human Services Office of Behavioral Health Bureau of Mental Health Services works in partnership with providers to deliver culturally competent, quality services that embrace the principles of resiliency and recovery. The Bureau supports each person's right to choose services that meet their individual needs.

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INTRODUCTION

The Contract Specifications Manual provides the terms and conditions applicable to the service or services being provided through a CONTRACT between the Allegheny County Department of Human Services (DHS) and a CONTRACTOR. This contract specifications manual for the Office of Behavioral Health (OBH)/Bureau of Mental Health is a supplement to the DHS Contract Specifications Manual General Requirements. By reference in the CONTRACT, the applicable sections or provisions of this Contract Specifications Manual are incorporated therein.

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

In addition, CONTRACTOR is required to comply with the Terms and Conditions of additional contract specifications, 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)

DEFINITIONS

The following words and terms, when used in this Manual, have the following meanings:

Act - Refers, as applicable, to the "Mental Health/Mental Retardation Act of 1966", or the "Mental Health Procedures Act of 1976".

COMPASS - An online tool for Pennsylvanians to apply for many health and human service programs and manage benefit information.

CONTRACTOR - An organization, agency, vendor, and/or individual that has a contract with Allegheny County, Department of Human Services, Office of Behavioral Health.

COUNTY- Allegheny County, Department of Human Services

Fiscal Year - A period of time beginning July 1 and ending June 30 of the following year.

Individual and Resident - Refers to persons receiving services supported by the Office of Behavioral Health.

PROMISe – The Commonwealth of Pennsylvania's Department of Human Services claims processing and management information system.

Regulations - Refers, as applicable, to Regulations promulgated under the Act by the Offices of Mental Health/Mental Retardation, Pennsylvania Department of Human Services, and Allegheny County's Department of Human Services.

SECTION 1 - CONDITIONS OF CONTRACT

CONTRACTOR 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 CONTRACTORS.

1. The COUNTY reserves the right to require the CONTRACTOR 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.

2. CONTRACTOR requesting a change to the approved activities, the location of activities and/or the addition, reduction or deletion of services purchased or to be purchased by the COUNTY from CONTRACTOR under the CONTRACT must submit a written request at least ninety (90) days prior to the anticipated change to the Allegheny County Department of Human Services (DHS) Deputy Director for the Office of Behavioral Health and receive a written approval.

3. CONTRACTOR shall permit an authorized designee of COUNTY to attend that portion of any and all such meetings affecting the program funded by the CONTRACT, and shall provide COUNTY at CONTRACTOR'S expense, with an accurate copy of that portion of the minutes of any such meeting within a reasonable time after its adjournment. The CONTRACTOR shall provide COUNTY with reasonable notice of the date, time and place of its Citizen Advisory Council meetings and Board meetings when appropriate.

4. CONTRACTOR agrees to provide on the execution of the CONTRACT, 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 Board of Directors Secretary or Assistant Secretary. CONTRACTOR 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 CONTRACT.

5. CONTRACTOR shall supply COUNTY with such individual and service information required by COUNTY for the purposes of management, accountability, and compliance with State and Federal reporting mandates, provided COUNTY'S requests conform with applicable laws relating to confidentiality and they include appropriate technical specifications as to the manner(s) and mode(s) in which information will be accepted.

6. CONTRACTOR may utilize outside consultants and vendors in designing and/or operating its management information system, but CONTRACTOR'S obligation to COUNTY is not transferable to any other party.

7. Performance Conditions

   A. CONTRACTOR shall comply with all Federal, State and County requirements relevant to services provided.
   B. CONTRACTOR shall permit reviews of all aspects of their respective services or activities as required by appropriate Federal, State, and County authorities. Such reviews shall be made available at any time during the term of the CONTRACT and may include reviews of individual records.
   C. CONTRACTOR shall provide OBH with any corrective action plans that are a result of licensure from PA Office of Mental Health and Substance Abuse Services or as a result from an OBH review.
   D. CONTRACTOR will develop and implement behavioral health recovery practices in a comprehensive way. (Appendix A)
   E. CONTRACTOR will follow the Child and Adolescent Services System Program (CASSP) principles as applicable. (Appendix B)
   F. OBH will monitor and evaluate performance throughout the fiscal year which includes but is not limited to:

      i. OBH Monitoring and Contract Management – On and off-site program reviews can occur for all agencies receiving funds to provide mental health services. These reviews may be announced or unannounced and include but not limited to programmatic; health and safety assessment; provision of services; data collection, storage, protection; fiscal review and individual satisfaction;
      ii. Ongoing review of Incident Management information;
      iii. CONTRACTOR's timely response(s) to requests for information from the OBH;
      iv. Significant and/or persistent failure to comply with conditions above may result in financial penalties or other sanctions.

8. Liability and Other Revenue - Collections by CONTRACTOR shall be based on the appropriate PA Department of Human Services Regulations (PA DHS), which indicates the various forms of liability for services.

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

9. COMPASS Community Partner Overview - Providers are required to pursue all private and public

funding and to enroll as "Compass Partners" with the County Assistance Office.

A. Organizations such as hospitals, church groups and other community-based agencies that help Pennsylvania residents apply for health and human services can register to become a COMPASS Community Partner.
B. By registering as a COMPASS Community Partner, your organization can initiate and track individual applications through the COMPASS Community Partner Dashboard.
C. There are three main steps to registering:

   i. Register your organization as a COMPASS Community Partner. The registration application can be found here: http://www.compass.state.pa.us
   ii. 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.
   iii. Register additional COMPASS users as needed.

10. Personnel Action Plan - CONTRACTOR shall employ all positions as required to fulfill the CONTRACT and in conformity with the Allegheny County Personnel Action Plan, subject to available funding for all program funded cost centers. CONTRACTOR must submit to COUNTY annually, with the CONTRACT, 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 CONTRACTORS whose positions are funded through a program-funded CONTRACT. CONTRACTORS, whose CONTRACTs 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.

11. Individual Right to Appeal - CONTRACTOR must develop and implement a policy on an individual right-to-appeal relating to treatment/services or payment decisions. This policy shall be given to individuals at intake, posted in public places throughout the agency, and reviewed on a regular basis with the individual during each year.

12. Citizen Participation - CONTRACTOR agrees to develop and implement a Citizen Participation Policy. CONTRACTOR shall actively seek citizen input and participation in planning, governance, policy formulation and other appropriate activities. CONTRACTOR shall make available to COUNTY upon request all such plans for citizen participation and input.

13. Individual Satisfaction - CONTRACTOR is expected to have a Quality Management Policy that includes Individual/Family satisfaction assessments. CONTRACTOR agrees to allow access to and provide interview space for County approved individual satisfaction activities on an annual basis.

14. Human Research Protections - All research with human subjects involving any physical or mental

risk to those subjects shall be prohibited without the following:

A. Prior written approval from the PA Department of Human Services Office of Mental Health and Substance Abuse Services (OMHSAS), subject to all applicable laws, statutes, and regulations;
B. Prior informed and voluntary written consent of the subject;
C. Prior informed and voluntary written consent of his/her parents or legal guardian, if the individual is deemed to be a minor or incompetent;
D. 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, CONTRACTOR, or any third-party insurer.

SECTION 3 – REGULATORY AND PERFORMANCE STANDARDS

CONTRACTORS are expected to adhere to Pennsylvania's State Department of Human Services' (PA DHS) licensing regulations as well as program standards developed by Community Care Behavioral Health and/or the Office of Behavioral Health (OBH).

For additional information on the publications, licensing regulations and bulletins for PA DHS, go to: http://www.dhs.pa.gov/publications/bulletinsearch/index.htm

Specific Community Care Behavioral Health program standards and can be found at http://www.ccbh.com/

OBH Standards and Best Practices are listed below:

1. Comprehensive Mental Health Personal Care Home (CMHPCH) Standards (Appendix C)
2. Service Coordination (Appendix D)
3. Service Support Best Practice Guide for OBH Residential Housing (Appendix E)

SECTION 4 - CONSOLIDATED COMMUNITY REPORTING INITIATIVE (CCRI)

Consolidated Community Reporting Initiative (CCRI) is the statewide data infrastructure for reporting individual-level service utilization and outcome information on persons receiving County base-funded mental health services.

As required by the Federal Government, the PA Department of Human Services Office of Mental Health and Substance Abuse Services (OMHSAS) must report individual-level information on: persons served, services rendered, the associated costs, and individual outcomes.

All providers must adhere to the corresponding bulletin: OMHSAS-14-30 dated August 1, 2014 which can be found here:
http://www.DHS.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/c_093853.pdf

Providers are responsible for enrolling, updating, revalidating and/or ending services in PROMISe per CCRI specifications.

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

Below are the required fields that must be completed for claims through Allegheny County DHS/OBH to be processed and paid.

1. Social Security Number
2. Last Name
3. First Name
4. Gender
5. Date of Birth
6. Address Line
7. City
8. State
9. Zip code
10. Address Type
11. Citizenship
12. Race
13. Ethnicity
14. Primary Language
15. County of Residence
16. Living Situation

For additional questions/concerns/job aids/etc. related to Client Information and Payment System (CIPS) reporting and submission of claims please submit a ticket to Allegheny County's Service Desk: servicedesk@alleghenycounty.us

SECTION 5 - INCIDENT REPORTING PROCEDURE

This procedure describes the process for reporting all types of incidents. This procedure applies equally to incidents involving CONTRACTOR'S employees and/or contracted staff, subcontractors and individuals that have received a publicly funded behavioral health service within 6 months of the incident (Eligible Individuals). CONTRACTOR will report all incidents as defined in this document to Allegheny County Office of Behavioral Health (OBH) within 24 hours of the incident or 24 hours of learning of an incident. To assure immediate, appropriate response to any incident/problem situation, CONTRACTOR will report any incident to any additional regulatory or government authorities or licensing bodies, as required. All CONTRACTORS will follow the incident reporting procedure and report appropriate follow-up actions/procedures to Allegheny County OBH within 48 hours of the incident.

1. Reportable Incidents

   A. Death - All deaths regardless of cause/manner;
   B. Suicide Attempt – Intentional attempt to take one's life limited to the actual occurrence that requires medical attention or the furtherance of suicidal ideation;
   C. Significant Medication Error – Includes a missed medication, incorrect dosage, where an individual suffers an adverse consequence that is either short-term or long-term in duration;
   D. Arrests and Any Event Requiring Emergency Services of the Fire Department or Law Enforcement Agency – (Not related to the presence of law enforcement during any activity governed by MH Procedures Act or testing of alarm systems/false alarms or 911 calls by individuals that are unrelated to criminal activity or emergencies);
   E. Abuse - Allegations of abuse are to be reported. For the purposes of reporting, abuse includes abuse of individuals by staff or abuse of individuals by others. Depending on the nature of the abuse, it may also constitute a crime reportable to police. Abuse includes:
   F. Physical Abuse – An intentional physical act by staff or other person which causes injury;
   G. Psychological Abuse – An act including verbalizations, which may emotionally harm, invoke fear or humiliate, intimidate, degrade or demean an individual;
   H. Sexual Abuse- An act or attempted acts such as rape, sexual molestation, sexual harassment and inappropriate or unwanted touching of a sexual nature of an individual by another person. Any sexual contact between an individual and a staff person is abuse;
   I. Exploitation- The practice of a caregiver or other person of taking unfair advantage of an individual for the purposes of personal gain, including actions taken without informed consent or with consent obtained by misrepresentation, coercion or threats of force. This could include inappropriate access to or the use of an individual's finances, property and personal services;
   J. Neglect – Neglect is the failure to obtain or provide needed services and supports defined as necessary or otherwise required by law, contract or regulation. This can include the failure to provide for needed care such as shelter, food, clothing, personal hygiene, medical care and protection from health and safety hazards;
   K. Injury of an Individual – only report if a county contracted residential provider or if occurs on agency property. Reportable Injury includes when an individual requires medical treatment more intensive than first aid;
   L. Non-Fatal Overdose – only report if a drug and alcohol contracted service provider;
   M. Illness of an Individual – only report if a county contracted residential provider and for identified CHIPP individuals Reportable Illness includes any life-threatening illness, any

involuntary psychiatric admission or any illness that appears on the Department of Health's List of Reportable Diseases. NOT REPORTABLE: Scheduled treatment, ER visits or inpatient admissions that result from individuals previously diagnosed, chronic illness where such episodes are part of normal course of the illness;

N. Missing Person – Any individual who is out of contact with staff without prior arrangement for more than 24 hours. A person may be considered in "immediate jeopardy" based on his/her personal history and may be considered missing before 24 hours elapse. It is considered a reportable incident whenever police are contacted about a missing person or the police independently find and return an individual, regardless of the amount of time missing;
O. Seclusion/Restraint – Providers are to report any use of seclusion or restraint as defined by MH Bulletin, "OMHSAS 02-01, The Use of Seclusion and Restraint in MH Facilities and Programs;"
P. Serious Nature/Other – Any interruption in service and/or closure of a program or other incident determined by agency Director.

2. Reporting Procedures

A. Verbal reports are required for all deaths and ONLY when fire or law enforcement are involved in the incident for the following categories. (Not related to the presence of law enforcement during any activity governed by MH Procedures Act or testing of alarm systems/false alarms or 911 calls by individuals that are unrelated to criminal activity or emergencies);

i. Death
ii. Arrest
iii. Suicide Attempt
iv. Abuse
v. Neglect
vi. Missing Person
vii. Injury of an Eligible Individual – Applies only to County contracted residential providers and their property.
viii. Serious Nature/Other

All adult mental health, child and adolescent mental health and early intervention CONTRACTORS will make a verbal report to OBH Information, Referral and Emergency Services (IRES) at 412-350-4457 immediately after stabilization of the incident but no more than 24 hours after the incident or within 24 hours of learning of an incident.

IRES Staff will request the following information for the Verbal Report:

i. Eligible Individual's name;
ii. Eligible Individual's date of birth;
iii. CONTRACTOR name;
iv. Type of incident;
v. Date of incident;
vi. Time of incident;
vii. Place of Incident;
viii. Type of housing;
ix. Brief description of the incident;
x. Systems the Eligible Individual is involved;

xi. Incident Follow-up;
xii. CONTRACTOR'S reporting staff name, contact information, supervisor's name and telephone number.

B. Submission of a Written Report

CONTRACTORS who are required to complete incident reporting via Enterprise Incident Management System (EIM)- Community Residential Rehabilitation (CRR) and Long-Term Structured Residence (LTSR) are to continue to utilize the EIM process for submitting reports. This will function as the written report therefore additional written reports are not required.

All other CONTRACTORS are required to submit the written incident report on the approved Allegheny County OBH Incident Form – which is available on the Allegheny County Department of Human Services Website at: https://www.alleghenycounty.us/Human-Services/Resources/Doing-Business/Current-Providers/Office-of-Behavioral-Health.aspx

ALL written incidents will be emailed to: IncidentReports@alleghenycounty.us

This written incident form should also be faxed to a Community Care Behavioral Health Organization (CCBHO) at (888) 251-0087 if the Eligible Individual is a CCBHO member. Please refer to CCBHO requirements for reporting Single Member Incidents.

3. OBH Processing of Incidents

Allegheny County OBH will review CONTRACTOR'S incident management policy and procedure on an annual basis. During licensing visits, program monitors will review provider progress notes for documentation that would meet incident criteria and then look for the corresponding incident in the Enterprise Incident Management system or OBH incident application.

To ensure the confidentiality of all CONTRACTOR staff, subcontractors and the Eligible Individual(s) involved, incident reports are stored electronically in a secure location. Incidents are logged in a secure electronic application where only approved OBH staff have access.

Allegheny County shall disseminate the incident information to the appropriate OBH staff (including Administration) to obtain additional follow-up information that may be needed. This follow-up may occur by telephone, email or face to face with staff which may or may not include a site visit and an electronic record review. This will be determined on a case by case basis.

The mental health incident details and follow-up information that are completed by the CONTRACTOR and OBH staff will be shared and emailed to the State Office of Mental Health and Substance Abuse Services (OMHSAS) and to CCBHO, if applicable.

On a weekly basis, OBH and CCBHO staff will meet to review and analyze the reported incidents from the previous week. In this meeting, OBH and CCBHO review the incidents to ensure all follow-ups have been competed timely and thoroughly. In this weekly meeting, incidents will be reviewed to determine if they rise to a sentinel event, described below, and whether a request for a Root Cause Analysis is appropriate.

4. Root Cause Analysis

OBH and CCBHO staff will review and discuss whether the mental health incidents meet the criteria for a Root Cause Analysis (RCA). On a case by case basis, OBH and CCBHO will identify the need for a RCA for sentinel events involving all CONTRACTORS.

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. For this process, the sentinel event will involve one or more Eligible Individual who receive or have received mental health services from a CONTRACTOR of the Allegheny County Department of Human Services or Community Care, or an event that impacts in a significant manner on the entire behavioral health system.

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 systemic 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.

Please refer to Allegheny County OBH Process for Root Cause Analysis of Sentinel Events- Revised June 2018 for further information on the RCA process. (Appendix F)

Upon request from the Allegheny County OBH or CCBHO acting on behalf of OBH, CONTRACTOR will conduct a Root Cause Analysis of a sentinel or incident and notify the OBH of any process, protocol or system(s) changes based on the results of that RCA. OBH will work in collaboration with Community Care Behavioral Health to coordinate the completion of these RCAs by CONTRACTORS. CCBHO will coordinate and facilitate all the RCA's for Allegheny County.

CONTRACTOR will complete the RCA at the CONTRACTOR site. Based on the completed RCA, the CONTRACTOR will submit the following information to Allegheny County OBH and CCBHO:

a. Identification of which levels of care participated in the review;
b. Date(s) that the clinical record review was completed for each level of care;
c. Name and title/role of the individuals interviewed and the date(s) of their interview(s);
d. Date(s) of the group RCA review, including a list of individuals that attended and their titles;
e. Date of management review, including who attended the review;
f. Submission of the action items that address the root cause(s) of the sentinel event with time frames and the department/individuals that are responsible for completing the items;
g. Identification of the system issues that were identified through completing the RCA.

SECTION 6 - CENTRALIZED RESIDENTIAL REFERRAL PROCESS

The Allegheny County Centralized Residential Referral Process is designed to manage all incoming residential referrals for adults age 18 and older with serious mental illness or co-occurring disorders requiring housing 24 hours a day, 7 days a week.

Allegheny County Department of Human Services (DHS) provides multiple levels of housing for individuals. These programs are designed to meet the needs of individuals who receive or are eligible to receive services through DHS. Mental Health Housing options range from a low level of staffing support to highly structured, secured facilities. The type of housing will depend upon the intensity of the support needed for recovery from mental illness. This includes ensuring the resident is receiving appropriate treatment, taking medication appropriately and has the necessary community supports. Depending upon the residents needs and the type of mental health housing, support and teaching of skills are provided for activities of daily living such as but not limited to cooking, housekeeping, bill paying, meaningful daily, activity, making appointments. The goal of each program is to support the resident in becoming as self-sufficient as possible while supporting each person's recovery journey.

Referrals for each Mental Health Housing option must go through the DHS Office of Behavioral Health (OBH) Residential Referral process using the Allegheny County Department of Human Service Portal (ACDHS).

Referral sources and residential providers must be trained on the use of the centralized referral application and receive log-in credentials.

The ACDHS Portal allows users to explore the Mental Health Housing options that the individual may be eligible to apply for as well as resources that may be of assistance. The MH residential application is part of the Synergy suite of DHS Applications and provides a referral and case management platform for MH residential providers and DHS staff.

Referral Process:

1. Log-in: The referral source is required to log into the DHS portal using a log-in ID and user password.
2. Housing Eligibility: This allows users to enter information about an individual to determine their eligibility.
3. Client Search: If there are no other current referrals for the individual a new referral can be created. The referral source can navigate in and out of various screens such as:
   A. Individual Information
   B. Referral Information
   C. Daily Living
   D. Referral Reason
   E. Residential Living
   F. Treatment History
   G. Risk Factors
   H. Legal History
   I. Level of Care
      i. Comprehensive Mental Health Personal Care Home (CMHPCH)

ii. Long-Term Structured Residence (LTSR)
iii. Community Residential Rehabilitation (CRR) - Apartment
iv. Community Residential Rehabilitation (CRR) - Group Home
v. Community Residential Rehabilitation (CRR) - Co-Occurring Group Home
vi. 24/7 Supportive Housing (SH)
vii. Specialized Residence (SR)
viii. Personal Care Home (PCH)
ix. Domiciliary Care (Dom Care)

J. Applicant Authorization
K. LTSR Acknowledgment
L. Document Folder
M. CANS/ANSA History
N. Referral Outcome
O. Placement Outcome
P. Referral Review
Q. Referral Notes
R. Referral Share

4. Dashboard: Once the referral is completed, a dashboard allows users to review assignments, referrals, and alerts. Incomplete referrals remain in pending status until they are completed entirely. OBH-Residential may reconsider referrals if the level of care, diagnosis, or reason for referral is questionable.

Admission/Discharge Process:

1. Within 3 business days of the CONTRACTOR becoming aware of the pending vacancy, the CONTRACTOR must enter the residential Discharge/Vacancy in the residential portal.

2. OBH staff will select the next person on the list to fill the vacancy and send the referral to the CONTRACTOR who reported the vacancy. Preference is usually given to individuals who are on the below priority list. Assignment of the bed is based who has the highest need and is usually determined at the OBH weekly vacancy meeting.

Priority List:

A. In a State Hospital (Civil)
B. In a State Hospital (Forensic Diversion)
C. On a Psychiatric Inpatient Unit with a County Disposition
D. On TRU (Transitional Recovery Unit)
E. On CRU (Comprehensive Recovery Unit)
F. In an RTFA (Residential Treatment Facility for Adults)
G. At the EAC (Extended Acute Care)
H. Community Integrated Team (CIT), Have a Community Support Plan (CSP) or Acute Community Support Plan (ACSP), or special case.
I. Residing in an LTSR and ready for a lower level of care
J. Transitional Age (TAY) being discharged from RTF with CYF involvement

K. TAY-Homeless
L. TAY- Conferencing and Teaming
M. TAY- Involvement with CYF past year
N. TAY-Integration and Teaming (ITM)
O. TAY-Involvement with 2 or more systems
P. TAY- Involvement with JPO past year
Q. Deaf and in need of American Sign Language (ASL) supportive services.
R. Capitalizing on a Recovery Environment (CORE)
S. Diversion and Acute Stabilization (DAS)
T. Involvement with other DHS services
U. Transfers

3. Alerts are also sent via email and through the portal to the Service Support Person or referral source to alert them of the status of the referral.

4. Within two (2) business days of the CONTRACTOR's receipt of the referral, the interview is to be scheduled.

5. Within three (3) business days after the interview has been scheduled, the tour/interview should take place. The CONTRACTOR is required to provide an overview of the program and expectations for the individual during the intake/interview.

6. Within 2 business days after the interview the individual has 2 business days to decide to accept the program (if applicable).

7. Within 2 business days after the tour/interview, the CONTRACTOR can request a Residential Treatment Team Meeting (RTTM). The meeting will be scheduled within 3 business days of the request. If the CONTRACTOR feels that the individual does not meet the criteria for their program or believes is unable to support the individual the CONTRACTOR will need to report this to OBH Housing Supervisor via email. 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.

8. Within 12 business days of the referral being sent to the CONTRACTOR, admission should occur. Reasons beyond 12 business days will be documented in the residential portal by the residential provider. Any admission over 12 business days from referral submission to the residential provider will be subject to review by Allegheny County, DHS-Office of Behavioral Health.

9. The CONTRACTOR completes the placement outcome section of the referral in the residential portal. This section of the referral includes: tour, Interview date, Move in date, and Residential Treatment Team Meeting if applicable.

Trial Visits:

1. Trial Visits are NOT required for admissions
2. 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 the CONTRACTOR.
3. The CONTRACTOR shall assess the trial visit and discuss the admission process with the individual and referral source.
4. 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.

Managing the Waiting List:

1. Service Support Providers will receive the following alerts:
    A. Referral has been accepted
    B. Referral has been sent to CONTRACTOR
    C. 3 days with no scheduled interview date
    D. 7 days with no move in date
    E. Quarterly review to update referral
    F. Annual review to update referral

2. Service Support Staff are to make updates to the referral. If updates are not made in the time frame set, referrals will automatically be removed from the wait list.

3. Referrals expire after one year from the original referral date. Expired referrals will be removed from the wait list if it is not updated in the portal.

SECTION 7: ROOM AND BOARD CHARGES

COUNTY requires CONTRACTORS of residential services to have a policy and procedure for rental/lease agreement and for collection of room and board charges. Below are the levels of care for residential services and the corresponding regulations for rental agreements and collection of room and board charges.

1. Community Residential Rehabilitation Services (CRRS)

§ 5310.34. Service agreement.

(a) There must be a written agreement between the CRRS provider and the client, which:

(1) Is negotiated during the intake process.

(2) Is signed by both parties.

(3) Specifies the arrangements and charges for housing and food.

(OBH Refers to Specification Manual: PA Code 55, Chapter 6200)

2. Domiciliary Care

§ 6200.16. Room and board charges from SSI benefits.

If actual room and board costs are 72% or more of the SSI maximum rate, the following criteria shall be used in establishing room and board rates:

(1) If a client is funded through the county mental retardation program exclusively, the client's share of room and board shall be 72% of the SSI maximum rate.

(2) If a client resides in a jointly certified domiciliary care and licensed community residential mental retardation facility, the client shall be assessed 72% of the SSI maximum rate which includes the domiciliary care supplement for room and board.

(3) If a client is funded through domiciliary care exclusively and resides in a certified domiciliary care facility, the Department of Aging's regulations apply. See 6 Pa. Code Chapter 21 (relating to domiciliary care services for adults).

3. Long-Term Structured Residence (LTSR)

§ 5320.11. Prerequisites to licensure.

To obtain licensure to operate an LTSR, a provider shall:

(1) Comply with Chapter 20 (relating to licensure or approval of facilities and agencies).

(2) Be identified in the approved county plan or its amendments as specified in Chapter 4215 (relating to annual plan and estimate of expenditures).

(3) Have a letter of agreement between the provider and the county administrator's office. The agreement will include:

(i) Admission and discharge authority and procedure.

(ii) Charges for care, including room and board, treatment and rehabilitation services, personal hygiene and laundry services and other personal care services.

(iii) Charges for residents' care may not exceed the resident's current monthly income reduced by a minimum personal allowance of at least $60.

(iv) Charges for residents' care may not exceed the actual documented costs of services.

(v) Payment mechanisms for LTSR services, including charges for which the resident may be directly billed.

(vi) A dispute resolution mechanism.

§ 5320.33. Resident/provider contract; information on resident rights.

(a) Within 24 hours of a resident's admission, the provider shall develop a written contract with the resident that meets the minimum requirements listed in subsection (b). The provider shall explain the contents of the contract to the resident and designated person, if any. The provider shall sign the contract and shall request the resident's signature. If the resident refuses to sign, the provider shall document the attempts made to secure the resident's signature. The provider shall ensure that the resident's refusal to sign has no bearing on the treatment or services subsequently provided.

(b) The resident/provider contract shall include, at a minimum, the following:

(1) The actual amount of allowable resident charges for each service or item.

(2) The party responsible for payment.

(3) The method for payment of long distance or collect charges for telephone calls.

(4) The conditions under which refunds will be made.

(5) The financial arrangements if assistance with financial management is to be provided.

(6) Limits on access to personal funds.

(7) The LTSR "house rules."

(8) The conditions under which the contract may be terminated, including cessation of operation of the LTSR.

(9) A statement that the resident is entitled to at least 30 days' advance notice, in writing, of the provider's intent to change the contract.

(c) Residents may be responsible for the cost of services or items not included in the per diem cost of care if these items are furnished at the request of the resident.

(d) In conjunction with explaining the contract, the provider shall give, and explain to, the resident written information on the resident's rights, on grievance procedures and on access to advocates, as specified at § 5100.52 (relating to statement of principle).

OBH refers to Specification Manual: PA Code 55, Chapter 6200, but with the $60 minimum allowance

4. Comprehensive Mental Health Personal Care Home/Personal Care Home

2600.25. Resident-home contract.

(a) Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

(b) The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

(c) At a minimum, the contract must specify the following:

(1) Each resident shall retain, at a minimum, the current personal needs allowance as the resident's own funds for personal expenditure. A contract to the contrary is not valid. A personal needs allowance is the amount that a resident shall be permitted to keep for his personal use.

(2) A fee schedule that lists the actual amount of allowable resident charges for each of the home's available services.

(3) An explanation of the annual assessment, medical evaluation and support plan requirements and procedures, which shall be followed if either the assessment or the medical evaluation indicates the need of another and more appropriate level of care.

(4) The party responsible for payment.

(5) The method for payment of charges for long distance telephone calls.

(6) The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

(7) The financial arrangements if assistance with financial management is to be provided.

(8) The home's rules related to home services, including whether the home permits smoking.

(9) The conditions under which the agreement may be terminated including home closure as specified in § 2600.228 (relating to notification of termination).

(10) A statement that the resident is entitled to at least 30 days' advance notice, in writing, of the home's request to change the contract.

(11) A list of personal care services to be provided to the resident based on the outcome of the resident's support plan, a list of the actual rates that the resident will be periodically charged for food, shelter and services and how, when and by whom payment is to be made.

(12) Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

(13) Written information on the resident's rights and complaint procedures as specified in § 2600.41 (relating to notification of rights and complaint procedures).

(d) A home may not seek or accept payments from a resident in excess of one-half of any funds received by the resident under the Senior Citizens Rebate and Assistance Act (72 P. S. § § 4751-1—4751-12). If the home will be assisting the resident to manage a portion of the rent rebate, the requirements of § 2600.20 (relating to financial management) may apply. There may be no charge for filling out this paperwork.

(e) The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract and pay only for the services received. Rescission of the contract must be in writing addressed to the home.

(f) The home may not require or permit a resident to assign assets to the home in return for a life care contract/guarantee. A life care contract/guarantee is an agreement between the legal entity and the resident that the legal entity will provide care to the resident for the duration of the resident's life. Continuing care communities that have obtained a Certificate of Authority from the Insurance Department and provide a copy of the certificate to the Department are exempt from this requirement.

(g) A copy of the signed admission contract shall be given to the resident and a copy shall be filed in the resident's record.

(h) *§ 2600.25a. Personal needs allowance for residents of personal care homes—statement of policy.*

The personal needs allowance for residents of personal care homes who receive Supplemental Security Income is $85.

The service needs addressed in the resident's support plan shall be available to the resident every day of the year.

5. Specialized Residence

(a) There must be a written agreement between the Specialized Residence provider and the client, which:

(1) Is negotiated during the intake process.

(2) Is signed by both parties.

(3) Specifies the arrangements and charges for room and board and food.

6. 24/7 Supportive Housing

(a) There must be a written agreement between the 24/7 Supportive Housing provider and the client, which:

(1) Is negotiated during the intake process.

(2) Is signed by both parties.

(3) Specifies the arrangements and charges for room and board and food.

SECTION 8: WEBSITE RESOURCES

It is the CONTRACTORS responsibility to regularly check for updated information from the various sites identified below:

COMPASS: http://www.compass.state.pa.us

Commonwealth of Pennsylvania DHS: http://www.dhs.pa.gov/publications/bulletinsearch/index.htm

Community Care Behavioral Health: http://www.ccbh.com/

Consolidated Community Reporting Initiative:
http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/c_093853.pdf

Incident Report Form: https://www.alleghenycounty.us/Human-Services/Resources/Doing-Business/Current-Providers/Office-of-Behavioral-Health.aspx

Department of Health List of Reportable Diseases:
https://www.health.pa.gov/topics/Reporting-Registries/Pages/Reportable-Diseases.aspx

Coalition for Recovery: www.coalitionforrecovery.org

MH Residential Electronic Application Portal: https://acdhsportal.alleghenycounty.us/Security/Login

OMHSAS Cost Centers for County Based Mental Health Services:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005967.pdf

Appendix A

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

Introduction

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 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.

The Guidelines have subsections composed of a general description of the recovery-oriented services with a set of two to four observable measures as indicators of services that are recovery-oriented. A section for references is provided here. On-going updates and revisions can be found 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. Recovery oriented administration involves new kinds of relationships with individual 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 individual in recovery, family members and significant others participate in the strategic planning process defined above.
- Individual in recovery are paid for participating in planning activities whenever possible.
- Mission and vision statements clearly state a commitment to helping individual 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 individual 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 individual 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 individual wearing glasses are nerds," or "all individual 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:

- Individuals in recovery know they are understood and respected by the professionals who serve them. The successes of individuals in achieving their goals are recognized and celebrated.
- Individuals 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 individual wherever they are on their journey to healing and health.

External Stigma

Individual 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 individuals 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 CONTRACTORs

All mental health and addiction professionals must have a thorough understanding of recovery concepts and a grasp of the perspectives of individual 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 goals.

Indicators:

- Individuals 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.
- Individuals 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 individual 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:

- Individuals 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 used by the organizations in identifying improvement areas and developing improvement plans.

Outcome Assessment

CONTRACTORs 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:

- Individuals in recovery contribute ideas for 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 clinical services 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 individuals rather than helping them to integrate with the community.

Empowerment

An important part of recovery-oriented services is the empowerment of individuals. Individuals 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. Recovery oriented CONTRACTORs recognize that individuals have the right to make choices about their own care. Shared decision making includes matters such as level of treatment and medication management. Individuals and families in recovery are capable and are accepting of responsibility for making informed choices regarding their own care and the results of these choices.

Indicators:

- Choices made by individuals are respected by CONTRACTORs.
- Individuals receive comprehensive and understandable information regarding service options and have opportunities to choose their services.
- Medication management is a shared decision-making process.
- Direct-care staff effectively educate 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 CONTRACTORs. 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, supported employment, and skill 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 CONTRACTORs 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/tempplates/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 individual 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:

- CONTRACTORs 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.
- CONTRACTORs 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 individual'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:

- CONTRACTORs 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. CONTRACTORs 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.
- When involuntary treatment is 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 individual. 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. CONTRACTORs 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 inflected.

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 based on the presenting needs of the individual. 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. 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 CONTRACTOR.
- 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 CONTRACTORs should encourage and assist the development and instruction of mental health advance directives with the individual that they serve. Whenever possible, Peer Support Specialists rather than providers should assist individual with their mental health advance directives. A mental health advance directive is a document that indicates an individual's wishes regarding treatment in the event he or she is unable to make decisions about her/his own treatment. The document may also indicate a person or persons empowered to make decisions on behalf of the individual, if necessary. 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. CONTRACTORs should give enough information to individuals so that they can make well-informed decisions. Individual should have opportunities to learn about and work on advance directives when they are in a reasonably good state of health.

Indicators:

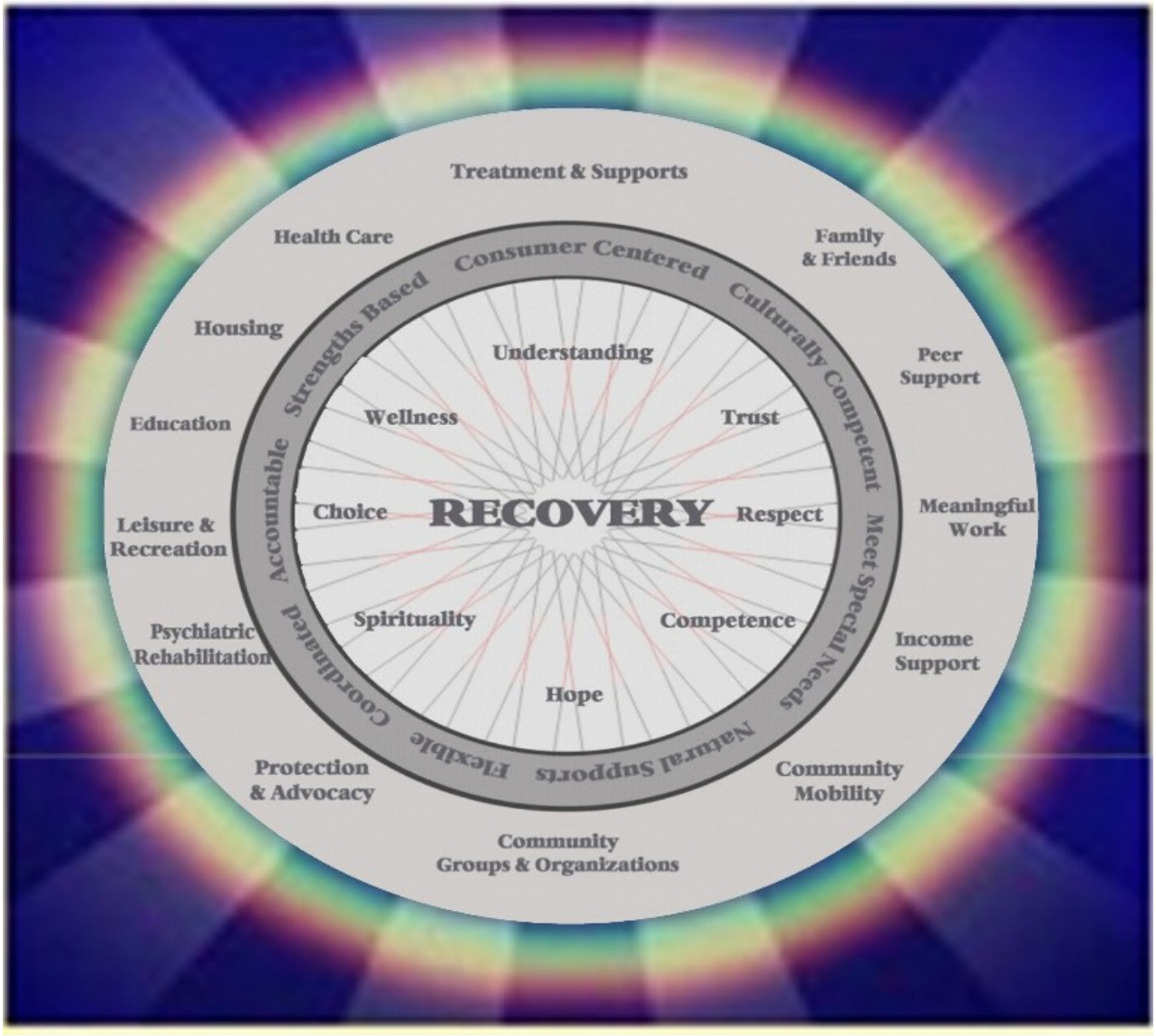
- Mental health advance directives and crisis plans are encouraged and respected by the organization.
- The CONTRACTOR organization reviews advance directives during periods where the person has relapsed, is in a crisis, or is unable to make decisions about his/her own care.

III. <u>Support Services</u>

Some individuals 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. CONTRACTORs should help individuals to identify their community support needs and to facilitate access to appropriate support services.

COMMUNITY SUPPORT PROGRAM RECOVERY WHEEL



PMHCA

PENNSYLVANIA MENTAL HEALTH CONSUMERS ASSOCIATION
1-800-88-PMHCA

Access to Community Support Services

Clinical CONTRACTORs should assess the community support needs of persons who come to them for assistance. Providers should be familiar with available resources and assist the individual 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 individual 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 individuals need meaning in their lives. Individuals 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 support involvement in work, volunteer, training, formal education, and other productive activities. Providers facilitate referrals or interventions that allow individuals to advance their careers through higher education or specific career training. Training and supported employment should be integrated with other services.

Indicators:

- Individuals 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 those 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 individuals 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 individual access and use information in a variety of formats. CONTRACTORs should support individuals 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 an individual with many satisfying experiences and access to a wealth of natural supports. Professional services should assist individuals in choosing and gaining access to such communities while they assist individuals in gaining the needed skills and supports to be successfully engaged with their chosen communities.

Indicators:

- Services help individuals in their recovery journeys learn about and participate in a wide range of opportunities for positive and meaningful involvement in various community roles.
- Individuals 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.
- Individuals in recovery are encouraged to expand the networks of social connections within their own communities.

Family, Friends, and Significant Others Support

Individuals 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 individuals 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 individual 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:

- Individual 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 individual 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 CONTRACTORs 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, CONTRACTORs 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.
- CONTRACTORs 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

Individual 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.

Appendix B

CHILD AND ADOLESCENT SERVICES SYSTEM PROGRAM 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 C

COMPREHENSIVE MENTAL HEALTH PERSONAL CARE HOME (CMHPCH) STANDARDS

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) CONTRACTOR staff on duty during the day and evening hours. Consideration should be given to the current individual needs in the home in determining the need for additional CONTRACTOR staff;

B. At all times, the CONTRACTOR staff to individual ratio should be maintained at no more than 15 individuals per staff person;

C. There must be at least 1 awake CONTRACTOR staff person at all times and a back-up plan for additional staff when necessary;

D. All CONTRACTOR 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 CONTRACTOR staff must be on site at all times;

F. There should be a minimum of 2 CONTRACTOR 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 CONTRACTOR staff when needed based on the individual's needs;

H. There must be a full-time registered nurse on the CONTRACTOR 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 CONTRACTOR's 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. CONTRACTOR must have a minimum of 1.5 FTE qualified cook with a Food Handler's Certification for every 15 individuals and an additional .5 FTE for every additional 5 individuals.

2. TRAINING (TO EXCEED THE PERSON CARE HOME REGULATIONS):

A. Within 30 days of beginning to work at the Personal Care Home, each CONTRACTOR staff person must receive an orientation that includes the following:

i. Overview of Mental Illness;
ii. The individual perspective;
iii. The family perspective;
iv. Psychotropic medications by a qualified instructor;
v. Individual rights;
vi. Confidentiality;
vii. Recovery model and philosophy;
viii. Crisis Intervention: It is recommended that this training be offered within the initial 30 days but mandatory that it occur within the initial 60 days.

B. There shall be a minimum of an additional 15 hours of training for each CONTRACTOR staff person annually;

C. A training plan shall be developed for each CONTRACTOR staff person to ensure that topics listed below are covered either annually or every two years as noted below:

1. Annual training shall include:

i. OSHA;
ii. Fire safety;
iii. Psychotropic medications by a qualified instructor;
iv. Crisis intervention;
v. Individual rights.

2. Every two years training shall include:

i. CPR/First Aid (as required by the certification);
ii. Recovery model and philosophy;
iii. MISA;
iv. HIV/AIDS;
v. Behavior management;
vi. Mental health service system;
vii. Intellectual disabilities/developmental disabilities;
viii. Confidentiality.

D. Training is required for all CONTRACTOR staff working in the personal care home, including housekeeping, maintenance and kitchen staff;

E. Additional training opportunities should be offered and available to all CONTRACTOR staff based on the individuals training plan;

F. A Food Handler's Certification is required for all CONTRACTOR staff working in or with access to the kitchen.

3. CONTRACTOR'S RESIDENT COUNCIL:

A. There must be a written policy regarding the role and process for the Resident Council;
B. There must be monthly individual/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 CONTRACTOR 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 CONTRACTOR 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 has a physical disability, 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 Primary Care Physician (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 treatment, vocational, educational and other support services for the residents;
F. 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 and document that PCH is the most appropriate setting for the individual.

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:

i. There must be a written process for eviction;
ii. 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;
iii. There must be written policy and procedures that includes the role of the Resident Council in reviewing all evictions;
iv. Written policy and procedures must require an interagency meeting and resident contract prior to any eviction;
v. There must be a written discharge plan for the resident developed in collaboration with the SCU or treatment team;
vi. There must be a written appeals process.

C. 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.

11. PERSONAL SPENDING:

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

12. INCIDENT REPORTING:

CONTRACTOR will follow unusual incident reporting requirements.

Appendix D

SERVICE COORDINATION

CONTRACTOR will provide Service Coordination Services (the Services) to individuals with serious mental illness and children diagnosed with or at risk of serious emotional disturbance (Eligible Individuals). The goal of the Services is to help Eligible Individuals gain access to needed medical, social, educational, and other services through natural supports, e.g. family or friends, community resources and specialized mental health treatment, rehabilitation and support services in order to achieve specific outcomes of independence of living, vocational/educational participation, adequate social supports and reduced hospitalization.

The CONTRACTOR shall provide Service Coordination in accordance with the standards and requirements set forth in Title 55 Chapter 5221 entitled Mental Health Intensive Case Management; and OMHSAS Bullentin 10-03 entitled Blended Case Management (BCM) Revised.

The exception to these regulations would be for Discharge Planning Service Coordinators, which requires approval from the Office of Mental Health and Substance Abuse Services. This level of support is available as an option for adult individuals 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 individuals. The average timeframe for this level of support is 1 year.

I. Design of Service Coordination Program:

It is expected that the CONTRACTOR's Service Coordination will consist of the following components, but not limited to:

1. Training: Develop Policies and Procedures to address the training needs for the expectations of the Service Coordinators. The policies should reflect the commitment of the agency to assure that all Service Coordinators and Supervisors receive and can demonstrate competencies in areas outlined by the New Hire Training Curriculum.

A. Five Day New Hire Training. All new hires are 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 CONTRACTOR 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.

B. Office of Educational Resources and Planning (OERP) 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. Improvement Goals: CONTRACTOR will set performance improvement goals for Service Coordinators, specific Service Coordination teams or the Service Coordination program as a whole. Goals will demonstrate a commitment to quality improvement and CONTRACTOR will provide evidence and outcomes of these established goals, upon request.

3. Contingency Funds: Develop policies and procedures around the uses of contingency funds. The CONTRACTOR will designate contingency funds in the Family Support Services Cost Center. It is the expectation that $1,125.00 per Service Coordinator per CONTRACTOR will be allocated to the Family Support Cost Center for the use of contingency funds.

CONTRACTOR's Policies and Procedures will include but are not limited to:
the following

A. Contingency Funds should be a last resort - All other financial resources should be exhausted first.

B. 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 individuals to implement skills and strategies to avert future financial crises.

C. Prevention of future crisis - Funds should be used to avert future crises, helping to build in the individual 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.

D. 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).

E. Pay back of Contingency Funds - Most individuals are expected to pay back contingency funds, teaching financial responsibility and the need to live within a budget. This is a better utilization of public mental health funds. CONTRACTOR will develop systems for tracking and collecting payments.

F. Contingency funds budgeting and year end utilization - CONTRACTOR will provide the County Monitor upon request with the budgeted amount the CONTRACTOR has allocated to Family Support Services for Contingency Funds. At the end of the fiscal year, the CONTRACTOR will provide a detailed report that shows the combination of Contingency Funds and all other monetary/non-monetary resources used in the Service Coordination program.

4. Recruitment and Retention:

A. Job Description/Performance Evaluations – CONTRACTOR will write responsibilities into job descriptions for Service Coordinators and into a performance evaluation format.

B. Individuals involved in hiring - Involving adult and older adolescent individuals, family members, and other peer supports in the CONTRACTOR's hiring process to help screen

applicants is encouraged. Evidence would include a procedure that describes the hiring process and how individuals are involved. Further evidence would include documentation of various methods of individual involvement.

C. Career Ladder - CONTRACTOR should create a career ladder for Service Coordinators to assist in retaining staff in Service Coordination programs:

   i. Training Mentors for new staff which may include either a children's Service Coordinator or a children's Service Coordination Supervisor.

   ii. Mentors for Adult staff which should include one mentor per team.

   iii. Senior service coordinators paid higher salaries to provide consultation to other staff.

   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).

D. Base Salary Floor – Base salary for Service Coordinators after completion of CONTRACTOR's probationary period must equal or exceed $32,000.

5. Responsibilities and Expectations: CONTRACTOR will build the 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.

6. 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).

7. Service Planning:

30% of program caseload has undergone the Service Planning process with Service Coordinators acting as convener/facilitator with the individual present and with other program representatives and friends/family members at the individual'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. Supervision Logs/Notes will reflect that service planning is occurring with all Service Coordinators.

CONTRACTOR will report when a Service Planning meeting has occurred with the Outpatient department utilizing the codes below based on therapist or psychiatrist involvement.

A. Treatment||Outpatient||Interagency Team Meeting||Psychiatrist Participation (Procedure Code: M0064EY)
B. Treatment||Outpatient||Interagency Team Meeting||Therapist Participation (Procedure Code: 90832EY)

8. Child and Adolescent Needs and Strengths (CANS)/Adult Needs and Strengths Assessment (ANSA): CANS/ANSA are a comprehensive communication and planning tool. CONTRACTOR's Service Coordinator will complete the CANS/ANSA with the individual within 30 days of CONTRACTOR accepting the referral. The CANS/ANSA needs to be completed prior to the development of the individual's service plan. The outcomes of the CANS/ANSA should drive the goals on the individual's service plan. The CANS/ANSA should be reviewed with the individual every 6 months at a minimum.

9. MH Advance Directives (Adults Only): Development of Mental Health Advance Directives is encouraged. At least 20% of the adult individual charts reviewed should show evidence that Advance Directives have been developed, or have at least been discussed, with individuals. 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.

II. SERVICE COORDINATION PROCESSING:

A. Referrals:

A referral for Service Coordination is completed on the Universal Referral Form and goes directly to Service Coordination Units (SCU). 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 connecting with another SCU that can provide SC services timelier. Other services that can support the individual such as peer supports, or psychiatric rehabilitation should be explored as well.

B. Discharges/Closures:

CONTRACTOR will send Service Coordination closures to the assigned County monitor in the following circumstances:

A. Individual disagrees with the closure/transfer;
B. Individual is not available to sign the closure/discharge summary- Individual may be incarcerated for an extended period;
C. Individual refuses to sign the closure/discharge summary;
D. Provider has determined that there are significant reasons why the individual should not be served in the program at the time;
E. Individual deaths;
F. Individuals that have not engaged in services.

C. Changes to process efficiency:

A. An email in place of a phone call may be sent to alert assigned County Monitors of a pending closure;
B. A certified letter is no longer required when it is known that individuals are not available for signature. A letter via U.S. Postal mail is still required, however, to inform individuals of the closure and where assistance may be obtained if needed;
C. The time requirement for outreach effort to locate individuals has been reduced from 90 days to 45 days. Significant efforts must be made during this timeframe to locate the individual;
D. If the individual 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;

Appendix E

Service Support Best Practice Guide (OBH Residential Housing)

Referral

1. Ensure, prior to making a referral that the individual being referred, and the individual's treatment team agree with the referral and the level of care being recommended.

2. Complete the residential referral with the most up to date and meaningful information. This will enable the residential provider to receive a complete overview of the needs, strengths and challenges for the individual being referred. Give a detailed explanation as to how the program will benefit the individual being referred.

3. Update new information in the electronic residential system as soon as the information is known (even if it is prior to the 6-month interval). In the electronic system, it is mandatory in the that information be updated every 6 months. The service support will receive an email alert to review the information at the 6-month point.

In these circumstances:

   i. The Service Support should make any updates to the referral or the request for a level of care change if the individual is currently in a residential facility.
   ii. The inpatient social worker typically completes the residential referral if the person is inpatient and not currently in a residential facility. However, discussion/collaboration should occur as to who will make the referral and complete any updates.

4. Monitor the individual's readiness status while on the waiting list and keep this up to date in the electronic system. An individual is considered ready for admission if a bed were to be available immediately and there isn't any reason that would prevent the individual from being admitted immediately. For example, an individual would not be ready if the individual is on a psychiatric inpatient unit, the psychiatrist had recently adjusted the individual's medications and wants to monitor the medications before discharging the person to the residential facility.

5. Respond as quickly as possible to any email alerts that you may receive regarding a referral.

6. Communicate with all members of the individual's treatment team consistently to assist with planning for the transition to the residential program. Attend treatment team meetings on the inpatient/step down unit to collaborate with the treatment team on the individual's needs.

7. Collaborate with the residential provider immediately to schedule the interview and tour (if needed), upon receiving notification that a referral has been sent.

   i. The interview should be scheduled within 2 business days after the referral is sent to the Residential Provider. The interview/tour should take place within 3 business days after the interview has been scheduled.
   ii. The individual has 2 business days after the interview to decide to accept the program.

iii. The residential site has 2 business days to request a Residential Treatment Team Meeting if indicated. The meeting will be scheduled within 3 business days of the request.

Admission

1. Placement must be considered a priority on the same level as an inpatient admission. Delays in residential housing visits/placements should not occur due to service provider staff planned days off or lack of ability to transport the individual. If unable to complete tasks that are needed for any reason, coordination to accomplish these should occur with team members. Plan for coverage!

2. Admission will occur within 12 business days of the referral being sent to the Residential Provider. Reasons for delays beyond 12 business days will be documented in the electronic referral system by the Residential Provider. Any admission over 12 business days from referral submission to the residential provider will be subject to review by Allegheny County, DHS - Office of Behavioral Health.

3. Coordination/collaboration will occur with the residential program for transportation needs. This includes transportation for interviews, medical appointments, and the transportation to the program the day of admission. Discussion will occur as soon as possible for everyone to have a clear understanding regarding transportation responsibilities.

4. Assistance will be offered to the Residential Provider if a treatment team meeting is required prior to admission. Service supports will assist the Residential Provider in scheduling the meeting and be prepared to offer suggestions and/ or coordinate services that will enable the individual to be successful.

5. Begin working as soon as possible on preparing any needed documents required for admission.

All Residential Placements require:

i. A Signed Psychiatric Evaluation stating the current diagnosis. Must be current within 6 months of admission into an LTSR, 1 year for CMHPCH. CRR apartment, CRR Group Home, PCH, MISA, and 2 years for Supportive Housing.
ii. A Signed Physical Exam. Must be current within 6 months of admission into an LTSR, MISA, CRR Apartment, CRR Group Home, PCH and 2 years for Supportive Housing. MA-51 completed within 60 days prior to admission for CMHPCH.
iii. Laboratory testing for Tuberculosis (TB). If test is positive, then a chest X-Ray is required. Test results must be current within 6 months of admission into any program.
iv. LTSR Only: An LTSR Certificate must be signed and dated by psychiatrist at the time of referral and updated again 30 days before admission. A copy of commitment form (304, 305 or 306) is required.
v. CMHPCH & PCH: An MA-51 must be signed by doctor 60 days prior to admission. A Diagnostic Medical Evaluation (DME) is required as well as the Preadmission Screening Form to be completed 30 days prior to admission. The Personal Care Home Assessment is to be completed by the PCH 15 days after admission.

Please ensure medical and psychiatric medication prescriptions or the 30-day supply of medication given matches the medication list on DME and MA-51.

6. Communication must occur frequently with the Residential Providers as to the status of needed items/tasks for admission to the program. This should include discussion of current clinical status, medications, prescriptions and any other special needs. Service supports should assist the resident with the application for any needed benefits as soon as possible.

7. Plan to be on site until all admission activities are completed. Ensure the individual has access to food, toiletry items, clothing and that prescriptions are filled.

Tenure

1. Schedule a meeting upon admission with the Residential Provider to occur within 7 business days for on-going collaboration/goal development

2. Develop goals within identified timelines if the individual is in a transitional type program (LTSR, CRR apartment, CRR group home etc.). These goals should be worked on collaboratively and referrals/linkage to needed services should be made as soon as possible.

3. Develop goals/care plans within identified timelines if the individual is in a permanent housing program (e.g. PCH, CMHPCH, 24-hour supportive housing, Dom Care). Should the residential program, along with the individual and the individual's treatment team decide another level of care is appropriate, then goals should be developed as appropriate for that transition.

4. Communicate frequently with the Residential Provider regarding status and needs of the individual during the tenure at the program.

5. Attend all scheduled treatment team meetings/utilization reviews. The Service Support may also ask for a treatment team meeting as needed.

Discharge

1. Coordinate with the Residential Provider during discharge planning to ensure the following needs are met: transportation, moving of personal belongings, access to food, prescriptions, medications medical/psychiatric appointments

If an unanticipated discharge occurs the Service Support should ensure, to the best extent possible, that the above needs are provided for.

Centralized Residential Information

To log into to MH Residential Electronic Application Portal, go to https://acdhsportal.alleghenycounty.us/Security/Login

For job aids and electronic training site contact http://s3.amazonaws.com/dhs-application-support/mh-res.htm

For technical assistance please email MH.Residential@alleghenycounty.us For business process questions please email OBHCentralizedreferrals@alleghenycounty.us Or call 412-350-5211

Appendix F

Allegheny County Office of Behavioral Health
Process for Root Cause Analysis (RCA) of Sentinel Events
June 2018

Overview

The Allegheny County Department of Human Services Office of Behavioral Health (OBH) shall be required by the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) to complete a Root Cause Analysis (RCA) on all incidents identified as meeting the definition of a sentinel event. OBH will work in collaboration with Community Care Behavioral Health (Community Care) to coordinate the completion of these RCAs by mental health service providers.

This requirement serves to help ensure a culture of consumer safety priorities and appropriate action/reaction when a sentinel event occurs. This methodology has a positive impact on the provision of care and services; assists in the prevention of similar incidents in the future; establishes a benchmark for improvement opportunities; and helps assert and maintain public trust in the services provided.

Root Cause Analysis is an investigative process that began in the airline industry to determine the underlying cause of airplane accidents. It was transposed to the health care setting in the mid-1990s by The Joint Commission. OMHSAS has utilized this process in the state hospital system since the mid-1990s.

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.

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. 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. An individual's active status with a provider and the mental health system is defined in section 2a of this document.

Examples of sentinel events involving person(s) include:

- An unanticipated death or serious injury to a consumer that results in a major permanent loss of function that is not related to the natural course of the person's illness or underlying condition;
- Apparent suicide/serious suicide attempt of a consumer receiving care, treatment or services in a mental health staffed care setting or within 72 hours of discharge from mental health care, treatment or services;

- Allegation/confirmation of a consumer being the victim or perpetrator of the following serious crimes: arson, attempted homicide, homicide, or rape. Other serious crimes will be considered as a sentinel event on a case by case basis after discussion with the provider.

Examples of systems sentinel events include:

- An unexplained and significant increase in adverse events associated with one particular provider or the mental health system as a whole.

Process

The Root Cause Analysis is a method of problem solving used for identifying the root causes of faults or problems. The process is designed to identify Quality Improvement recommendations for the Allegheny County Behavioral Health System.

OBH and Community Care have established policies and procedures to ensure the reporting, prompt review and needed follow-up of significant incidents involving current or former mental health consumers in Allegheny County. Some significant incidents will also be determined as sentinel events and a RCA investigation may be a part of the needed follow-up activities. In order to expedite this process, it is essential that the provider incident report be as detailed as possible. OBH staff may also contact the provider to request additional information regarding the reported incident. This process will outline the steps for identifying, initiating and conducting RCAs for sentinel events in Allegheny County:

1. OBH and Community Care will meet on a weekly basis to review significant incidents that have been reported involving mental health consumers in Allegheny County. After the review, when it is determined that a sentinel event has occurred in the community, Community Care will notify the individual's provider(s) (including Outpatient, Service Coordination, Community Treatment Team and Residential Program) that they will need to complete a RCA investigation of the identified sentinel event. RCAs may be requested from multiple organizations for individuals receiving services from multiple providers. For high profile and/or very serious incidents, OBH and Community Care may initiate the RCA process immediately upon learning of the incident, prior to the weekly review. Also, a provider may initiate a RCA investigation prior to a request from Community Care and OBH.

2. When an incident is identified as a possible sentinel event:

    a. OBH and Community Care will review the individual's active status with the mental health system. Actively connected with mental health services is defined as having three or more contacts within an episode of care within six months of the incident, or any combination of mental health inpatient and community mental health services within six months of the incident.

    b. The Provider involved may be requested to provide additional information or clarification regarding the incident prior to initiating a RCA.
    c. In the event of a consumer's unanticipated death, confirmation of the cause of death from the coroner may be needed to determine if the incident should be considered a sentinel event requiring an RCA.

d. The Provider may request consultation with OBH and Community Care with questions or concerns and to discuss whether the incident should be considered a sentinel event requiring a RCA.

3. To assist in maintaining confidentiality of specific mental health consumer and provider information, Community Care will assign a unique identification code to each sentinel event being reviewed in the RCA process and this code will be used in all RCA communications related to that sentinel event.

4. Community Care will be available to provide technical assistance on the RCA process for providers as needed.

5. A RCA is required to be completed by the provider within **one month** of notification from Community Care. If the provider is unable to meet this timeframe, notification should be made to Community Care. Once the RCA is completed by the provider, the following information is required:

   Submission of information to Community Care:

   h. Identification of which levels of care were involved in the incident/review,
   i. Date(s) that the clinical record review was completed for each level of care,
   j. Name and title/role of the individuals interviewed and the date(s) of their interview(s),
   k. Date(s) of the group RCA review, including a list of individuals that attended and their titles,
   l. Date of management review, including who attended the review,
   m. Submission of the action items that address the root cause(s) of the sentinel event with time frames and the department/individuals that are responsible for completing the items,
   n. Identification of the system issues that were identified through completing the RCA

6. If a provider requires additional assistance with the RCA, OBH and Community Care will be available upon request.

7. Written clarifications of information in the RCA report, including action items and systems issues, may be requested by OBH and Community Care after the RCA review.

8. Providers will be required to submit a report of quality improvement action items and/or system issues identified through the RCA process to Community Care per incident, or on a monthly or quarterly basis, depending upon the volume of activity. These reports do not need to be specific to an identified RCA. After reports are received from providers, Community Care will compile an ongoing list of the identified system issues.

   Upon completion of the provider RCA process for a sentinel event, any written RCA reports, with the *exception* of the report on action items and system issues, held by Community Care will be destroyed, or upon request, returned to the provider.

   The summary report of system issues compiled by Community Care will be forwarded to OBH. OBH and Community Care will review the summary with behavioral health providers at a regularly scheduled quality meeting.

9. In addition to the RCA request, Allegheny County and Community Care reserve the right to perform a chart/electronic health record review of the individual(s) involved in the sentinel event and/or discussion with provider staff on remediation of the event.

10. Providers are responsible for implementing and monitoring the implementation of their action plans that result from a RCA. OBH will follow up with providers to monitor the progress of implementation of the identified action items.

11. OBH will be responsible for reviewing the system issues and recommendations and, in collaboration with Community Care and providers, will develop a plan for system improvements.