

C·B·H



**Community Behavioral Health
Credentialing Manual**

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INTRODUCTION

In 1997, the City of Philadelphia entered into a contract with the State of Pennsylvania, through its HealthChoices program, to offer behavioral healthcare to the Medicaid population within the County. Community Behavioral Health (hereinafter, “CBH”) became the third operating arm of what is now referred to as the Philadelphia Behavioral Health System (hereinafter, “BHS”) alongside the county Office of Mental Health (hereinafter, “OMH”) and the county Coordinating Office for Drug and Alcohol Abuse Prevention (hereinafter, “CODAAP”). In March 2003, the BHS released its plan of integration to formalize the coordination of these three entities into one structure.

Additionally, the BHS has developed a strong and close collaboration with the Philadelphia Department of Human Services (hereinafter, “DHS”) that includes the sharing of staff, coordinated resource planning and clinical management for those children and families that are shared in common with CBH and DHS.

As a not for profit entity, CBH assumes the responsibility for delivering behavioral healthcare services throughout its provider network. Therefore, all CBH providers who agree to deliver behavioral health services to this consumer population are held to the tenets of the “Managing by Outcomes” approach that constitutes the City of Philadelphia’s contracting philosophy.

The City of Philadelphia has adopted this Quality Management strategy that relies on performance-based contracting whereby Providers are expected to achieve specified outcomes to which they assented in the Provider Agreement.

To achieve this citywide goal, the BHS has constructed an Outcomes Initiative that details a system wide approach to monitoring provider performance. This Outcomes Initiative forms the core of performance-based contracting for all CBH providers. The four basic elements of the BHS Outcomes Initiative are effectiveness, efficiency, accessibility, and appropriateness/high quality of care. These basic elements, when incorporated into the service delivery model, ensure that the treatment needs of the consumer will be addressed.

Performance-based contracting is also the method that the Pennsylvania HealthChoices Program has selected statewide to monitor and improve the managed care organizations that deliver Medicaid services. The BHS will also be held to the standards outlined in this manual.

By way of definition and shared references, the following terms are offered to improve clarity of communication around the discussion of quality care:

- **Quality Management:** the conceptual commitment of an organization to offer high quality services to its consumer population.
- **Quality Assurance:** the development of an ongoing internal management program to achieve the quality goals outlined by an organization.
- **Quality Monitoring:** the selection of quality indicators that measure the organizational progress towards stated goals during a defined period of time.

OVERVIEW

CBH, the Medicaid managed care component of the BHS, offers providers the opportunity to determine the credentialing process under which they will function and receive oversight while providing behavioral healthcare services to the CBH consumer population.

CBH remains committed to providing high quality care. The CBH Credentialing Manual is referenced in the CBH Provider Manual as the standard to which providers will be held. The CBH Provider Manual, in turn, is referenced in the CBH Provider Agreement and serves as an extension of the contract with the City of Philadelphia.

In addition to the CBH credentialing process, there are three (3) accrediting bodies from which a provider may choose to gain entrance into the CBH network. These accrediting bodies include the Joint Commission Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation (COA), and the Commission on Accreditation of Rehabilitation Facilities (CARF). All providers, regardless of the monitoring body by which they select to be reviewed and evaluated, are responsible for adherence to the standards set forth in this manual. In all cases, minimum standards imposed by the State will be met; however, CBH continues to reserve the right to impose standards above the State minimums.

If the provider chooses the CBH process, quality monitors will be implemented based directly on the results of the CBH (re)credentialing review. These identified quality indicators will be reviewed on an annual basis.

When the provider is accredited by one of the three aforementioned organizations, CBH will accept the outcomes of the alternate accrediting body's survey review. However, CBH will reserve the right to review any and all areas of the provider's operation using the current standards of care as they pertain to "best practice" and quality of care delivery.

CBH will continue to review the Quality Assurance Plan of all providers regardless of the accreditation process. It will be expected that the survey results from any accreditation source will generate an appropriate Continuous Quality Improvement (CQI) Plan that reflects the findings. CBH will review these plans on an annual basis to monitor progress towards the stated CQI goals.

CBH reserves the right to require any and all providers to include specific quality monitors based on the BHS Outcomes Initiative or from information generated about a specific provider from other sources.

No CBH provider may appear on the list of precluded providers found on the Medichk list generated by the Department of Public Welfare. The Medichk list and updates are issued through the Department's web site at: www.dpw.state.pa.us/omapmedchk.asp.

All requests to enter the CBH network as a contracted provider should be forwarded in writing to: C.B.H., Director of Provider Network Operations, 801 Market Street, 7th Floor, Philadelphia, PA 19107. Entrance into the CBH network is no longer based on “any willing provider.” Instead, a new provider will be given the opportunity to enter the CBH network based on one of three criteria:

- A need in a specific geographical location,
- A provision of a service identified as a gap or access issue,
- A provision of high quality of care as demonstrated by achieving a minimum score of 81% on all areas detailed in the CBH credentialing manual.

CBH expects that each provider will adhere to all standards, laws, and guidelines that are established by federal, state and discipline-specific licensing and/or oversight bodies. Each provider is expected to demonstrate the processes used for credentialing staff and ensuring quality of care, following CBH guidelines and standards. Again, minimum standards imposed by the State will be met; however, CBH reserves the right to impose standards above the State minimums in certain instances.

ACCREDITATION BY APPROVED NATIONAL ORGANIZATIONS

The process of accreditation to be maintained as a provider in the CBH network, under an approved accrediting body, will include a visit to the provider site at which the survey results, physical plant, and the Quality Assurance Plan will be reviewed with a designated representative from the agency. CBH will gather this information and, upon review, will recommend a credentialing status commensurate to that granted by the national accrediting body to the CBH Board of Directors for approval. Each agency will offer a corrective plan of action within two weeks from the site visit, when appropriate. This corrective action plan will be reviewed and approved or with suggested changes.

A provider requesting entrance into the CBH network will undergo its initial credentialing under the CBH process. Subsequent re-credentialing can follow the process detailed above.

CBH Delegated Credentialing

The CBH system of delegated credentialing offers providers the opportunity to establish and maintain their own credentialing process while meeting the standards established by CBH. Through the delegated credentialing process, the provider will follow the guidelines necessary to ensure quality of care as determined by CBH.

Providers will be responsible for adherence to standards described within this manual. Delegated credentialing enables each provider to set its own standards of excellence, while following the guidelines determined by CBH. The process of delegated credentialing holds each provider responsible for:

- Establishing a method of credentialing for all direct care and supervisory staff.
- Developing and maintaining standards of best clinical practice, both discipline and provider specific.
- Identifying methods of assessing quality of care through written standards.
- Determining outcome standards that measure aspects of care based on the results of treatment, which includes consumer satisfaction.

The process of delegated credentialing allows CBH site reviewers to evaluate each provider's compliance. Evaluation of compliance is accomplished through:

- Review and assessment of the provider's policies and procedures.
- On-site review of physical plant.
- Review of direct care and supervisory personnel files to verify compliance with established standards necessary for each position.
- Review of job descriptions for each position.
- Review of staffing patterns.
- Review of program descriptions.
- Review of the provider's Quality Assurance Plan.
- Review a random sample of clinical charts.

CBH CREDENTIALING VISIT

As noted above, the CBH credentialing visit will encompass a review of the provider's physical site, policies and procedures, staff credentialing files, quality assurance plan, and clinical charts. The Credentialing Specialist will notify Providers regarding the length and the scope of the credentialing visit at the time of the initial telephone contact.

The credentialing team is often accompanied by the compliance auditing team. This will continue to be the usual practice as it often saves the provider from hosting two (2) separate reviews.

On the date of the review, the credentialing team will arrive at 9:00am, unless otherwise arranged. The review is expected to commence at 9:30am. Reviewers may take a lunch break or may opt to work straight through the day. A discussion of the day's findings will begin at 4:00pm, unless otherwise arranged, and should last approximately 30-60 minutes.

Each provider is responsible for maintaining and providing verified copies of the following documentation:

- A current CBH Provider Application (*for initial credentialing only*).
- Provider Verification Form (**Note:** *The Credentialing Specialist will provide this document in advance of the site review*).
- Current state facility license(s) (e.g., Outpatient, Partial, Inpatient).
- Proof of Medical Assistance agreement numbers (i.e., the spreadsheet from Department of Public Welfare).
- Internal Revenue Service (IRS) Form W-9 (*for initial credentialing only*).
- Current proof of certification from the identified accreditation body, *if applicable*, (i.e., JCAHO, CARF, COA), including a copy of survey results and subsequent corrective action plan.
- Current and accurate staff roster of all direct care staff from top to bottom containing the following information: provider name, address, current date, level of service, employee name, date of hire, job titles, degrees, licenses/certifications, numbers of hours worked per week per site, caseload number, and C.P.R. certification status. For physicians (e.g., psychiatrists) appearing on the roster, their scheduled days and the hours worked on those days.
- Program descriptions (*initial credentialing or programs that have changed only*).
- Corporate structure and list of Board of Directors.
- DEA certificates and licenses of all physicians who provide direct care to CBH consumers.
- Licenses of psychologists, nurses, and social workers if being licensed is a job requirement.
- Certifications of addiction counselors.

The Provider will also furnish quality improvement documentation including:

- Peer review process and outcomes.
- Clinical monitoring process and evaluation results.
- Continuous quality improvement process.
- Member satisfaction surveys.
- Grievances and complaints process.

The auditing team will require an adequately sized, comfortable room with sufficient seating, a large table on which to work, and adequate lighting. In addition, there should be a designated contact person who will be available for questions by telephone or in person, along with access to a photocopier and a telephone.

After completion of all aspects of the review, the credentialing team will meet for an overview of its' findings, only unresolved issues and major concerns regarding the site visit will be discussed. At this meeting, instructions will be given to the provider as to the format of the Corrective Action Plan to be submitted to CBH and the timeframe by which it is to be submitted. A formal written narrative of the credentialing visit will be sent to the provider within approximately four (4) weeks of the site visit.

Written Credentialing Summary

Our process is continually evolving to suit the needs of CBH members as well as in response to the feedback from our providers. The previous format of the written Exit Summary gave providers a comprehensive review of their Staff Credentialing Files, Policies and Procedures Manual(s), and Clinical Documentation. This type of summary will be available only to those providers who request it. A new narrative summary format focusing on quality of care/service is now the standard, effective June, 2003.

This new version of the written Exit Summary will provide a narrative review of (re)credentialing audit findings that require improvement, divided into the various areas of our auditing tools. This method will allow providers to respond individually/creatively in their Corrective Action Plans. Providers will be expected to include critical areas of improvement in their Continuous Quality Improvement (CQI) Plans for the coming year, which will be monitored by Provider Network Operations. Wherever possible, CBH will coordinate these efforts with other arms of the Behavioral Health System and with respect to outcome initiatives.

Discussion will focus primarily on the following areas:

Staff Files

Urgent matters, such as absent Child Abuse checks and Criminal History checks (100% compliance is required for both), unverified academic endeavors related to the job position, or missing/expired licenses will be highlighted within the general narrative of deficiencies.

Policies & Procedures Manual

Missing, incomplete, or unacceptable/inadequate policies and procedures will be listed and categorized with the instruction to the provider to refer to the BHS Accreditation Manual for our requirements.

Clinical Documentation

The narrative will indicate the areas needing improvement under the headings of their respective clinical elements:

- Intake Documentation.
- Biopsychosocial Assessment.
- Comprehensive Biopsychosocial Evaluation.
- Treatment Plans.
- Progress/Session Notes.
- Discharge Documentation.
- Medication Management.
- PRN Medications (*if applicable*).
- Suicide Precautions (*if applicable*).
- Restrictive Procedures. (*if applicable*).

Additionally, the Credentialing Summary will include case-specific clinical observations as well as systemic issues as they relate to serious quality of care concerns.

Quality Assurance

The provider's Quality Assurance Plan will be reviewed, and the narrative will comment on its appropriateness, depth, demonstrated implementation, and results. Suggestions for future Quality Monitors or Quality Improvement Projects may be noted.

The Scoring System

This section provides you with a brief overview of how the Provider Network Operations department of CBH makes decisions throughout the review. It defines how the data is gathered on three (3) components of a credentialing site visit (Staff Files, Policies and Procedures, and Clinical Records), and how the data is converted into scores. These scores are used as the basis for recommendations presented to the CBH Board of Directors for its review and approval of status category (*see*, page 9). A site visit is conducted by a reviewer or by a review team. Reviewers assess adherence to standards through an examination of documents, including policy manuals, staff files, and clinical charts. Each element scored receives a **0**, **1**, or **2**. All scores are then entered onto the review score sheet at the time of the site visit. There may be circumstances under which particular policies and/or standards do not apply to a particular provider or service. In those instances, the element is marked 'N/A' and is not counted in the total score.

The Scoring Scale

Score: 0 = The Provider lacks the standard/category/policy in its entirety, or three (3) or more of the requisite elements are missing. *

Score: 1 = The Provider meets the intent and provisions of the standard/category/policy, and no more than two (2) requisite elements are missing. *

Score: 2 = The Provider meets the intent and provisions of the standard/category/policy, and no more than one (1) of the requisite elements is missing. *

*** Subject to change due to standards/categories/policies not possessing a significant number of elements.**

The site visit process culminates in a completed series of scored worksheets that provide an overview, expressed numerically, of the agency's level of compliance with the standards/policies under which it was reviewed. It is a simplified numerical expression of organizational performance and serves as the basis for the status approval made by the CBH Board of Directors. Individual element scores are compiled into a ratio for each reviewed category; a cumulative ratio score results in an overall percentage for each of the four areas noted above.

Note: A provider with multiple programs will receive an overall agency score no higher than its lowest scoring program.

Presentation of Review Results/Findings to the Board

Overall agency scores in the three (3) areas of review: Staff Credentialing Files, Policies and Procedure, and program specific scores in clinical charts, are assigned to one (1) of the following categories:

- **Category: 1** (60% or below)
- **Category: 2** (61% to 80%)
- **Category: 3** (81% and above)

Based on, but not limited exclusively to, the assignment of the categories, the CBH Board of Directors will designate one (1) of the following credentialing status options:

2 year status

The provider must attain a category “3” in **all** areas of review to be eligible for a two (2) year credentialing status.

1 year status

The provider must attain a minimum of category “2” in **all** areas of review to be eligible for a one (1) year credentialing status. **Note:** New providers may not receive greater than a one (1) year status.

6 month status

The provider who receives a category “1” score **in any one area of review** will attain a six (6) month status.

3 month status

At the discretion of the CBH Board of Directors, a provider will receive this status when a significant issue (or issues) has been identified by CBH as being in need of immediate correction.

Denial of Credentialed Status

The process of credentialing and/or recredentialing applies equally to all providers that wish to enter into and remain within the CBH network. The CBH Board reserves the right to deny a credentialing status when a provider has failed to offer:

- A safe and secure environment.
- Adequate treatment.
- Qualified staff.
- Appropriate licenses.
- Medical Assistance agreement.
- Required insurance coverage.
- Full compliance with child abuse clearances.

Staff Credentialing Files

Providers shall maintain credentialing files for all part-time/full time direct care (*including consultants, subcontracted employees, and students/interns*) and supervisory staff. Staff will meet the minimum requirements of the position description guidelines established by CBH, as well as the provider's own job qualifications (*See*, appendices B & C). All staff identified during the credentialing process as not meeting minimum qualifications for their assigned job position shall be reported to the Compliance Unit of CBH. Within each staff file, providers will maintain the following documentation:

- A completed CBH application (**Note:** the *individual* or *physician/psychologist* application).
- Resume/curriculum vitae for degreed staff (**Legal Reference:** 28 Pa Code §709.26(d)(1)) **or**, an employee application and/or resume for non-degreed staff (**Legal Reference:** 28 Pa Code §709.26(d)(1)).
- Job description for position with minimum degree and experience required, signed and dated on the date of hire, by both employer and employee. (**Legal Reference:** 28 Pa Code §709.26(f)(1)(2)(3)).
- Credentialing files of staff employed less than one year will contain verification of two (2) prior employers. Credentialing files of staff employed more than one year but less than two (2) years will contain verification of two (2) prior employers, and the employee's most recent performance evaluation. Credentialing files of staff employed more than two (2) years will contain their two (2) most recent performance evaluations (**Legal Reference:** 28 Pa Code §709.26(d)(2)(5)).
- Current valid licenses and/or certifications. (**Legal Reference:** 28 Pa Code §709.26(d)(3)).
- Confirmation of minimal degree status for current job position (**Legal Reference:** 28 Pa Code §709.26(d)(3)).
- Evidence of degree verification of all foreign-trained staff by an accredited educational verification Agency (e.g., Education Commission on Foreign Medical Graduates, World Educational Service, or other NACES members).
- Clear and convincing evidence of the completion of mandatory & ongoing in-service trainings, as required. **Note:** *See* "Ongoing In-service Training" (pg. 16) for **example** of standard.
- If any employee is not named under the provider's insurance policy, a copy of the insurance face sheet must be available for review. Proof of adequate liability insurance will be \$2,000,000/occurrence and \$2,000,000 aggregate. All physicians will meet the insurance standard set by the State in accordance with the current PA Catastrophic fund requirements.
- Current (updated every two (2) years) child abuse clearance (Act 33) for all direct care staff that have contact with children and adolescents.
- Current (updated every two (2) years) Pennsylvania criminal history checks for all direct care staff. **Note:** In addition to the PA criminal history clearance, staff who work in either children's or geriatric treatment services and who presently live outside Pennsylvania are required to have an FBI criminal history clearance through either ChildLine and/or the Department of Aging. (**Legal Reference:** 35 P.S. §10225.502(a)(2); *see* 28 U.S.C.A. §534(a)(1)).
- Current CPR certification for an adequate (50%) number of staff. **Note:** All physicians shall be CPR certified. For children's residential treatment facilities and day treatment programs, 100% of the staff must be C.P.R. certified (**Reference:** PA Bulletin, Volume 29, No. 26, June 26, 1999). **Note:** CBH requires 100% compliance for children's programs.
- National Practitioner Data Bank check for all physicians (updated every five (5) years).
- Current D.E.A. certificates for all prescribing practitioners.

NOTE: A **verified** copy is required for all original documents. Verification requires an authorized staff signature, date, and the phrase "original seen" legibly written on the copied document.

Guidelines for Independent Practitioners

A group practice is defined for the purposes of CBH as a partnership between associates joined together to provide a service or services. The partnership is understood to assume all risks and liabilities for every group practice member therein, unless otherwise indicated by the professional liability insurance contract. All group practices will be held to the same standards as documented above.

An independent practitioner is defined by CBH as a sole practitioner who, as an individual, is understood to assume all risks and liabilities for clinical practice as indicated by professional liability insurance. Credentialing files will be maintained for independent practitioners. The file will include:

- Completed CBH application (physician/psychologist).
- Resume or Curriculum Vitae.
- Current (within two (2) years) child abuse clearance (*if consumers include children/adolescents*).
- Current (within two (2) years) Pennsylvania criminal history clearance. **Note:** In addition to the PA criminal history clearance, staff who work in either children's or geriatric treatment services and who presently live outside Pennsylvania are required to have an FBI criminal history clearance through either ChildLine and/or the Department of Aging.
- Current CPR certification.
- Verification of current licenses and/or certifications.
- If any employee is not named under the provider's insurance policy, a copy of the insurance face sheet must be available for review. Proof of adequate liability insurance will be \$500,000/occurrence and \$1,500,000 aggregate, as well as evidence of participation in the PA Catastrophic Fund.
- Current D.E.A. certificate for all prescribing practitioners.
- Documentation of National Practitioner Data Bank check (updated every five (5) years)
- Evidence of degree verification of all foreign-trained staff by an accredited educational verification agency (e.g., Education Commission on Foreign Medical Graduates, World Educational Service, or other NACES members).

Staff File Scoring System

Academic Degree Confirmation

- **0** = No documentation exists verifying employee's educational background, or the documentation is insufficient (e.g., evidence of degree conferred on educational transcript is absent), unreadable or altered in any capacity. Staff files do not contain evidence of degree verification of all foreign-trained staff by an accredited educational verification agency (e.g., E.C.F.M.G., W.E.S.).
- **1** = Documentation exists concerning education, but has the following deficiency:
 - The copies of the degree/transcript are not 'verified.'
 - Telephone verifications of degree status are not signed and dated by authorized staff.
- **2** = Original **or** verified copies of educational degrees/transcripts are present. Telephone verifications of degree status are present and signed and dated by authorized staff.

Child Abuse Clearances

- **0** = A child abuse clearance is NOT present within the staff file, is expired (e.g., two (2) years or older), unreadable, contains wrong information (e.g., date of birth, social security number, name), **or** has been altered in any capacity.
- **1** = A child abuse clearance is present, but has one (1) or more of the following deficiencies:
 - The child abuse clearance is present, but is not verified.
 - The child abuse clearance is present, but contains a child abuse report that needs follow-up investigation that was not completed.
 - Requests for updated child abuse clearances do not possess a copy of the money order/check that was sent with the application.
 - Request for updated child abuse clearance does not have the date it was sent.
- **2** = A current, clear, original child abuse clearance **or** a verified copy is present.

Credentialing Application

- **0** = A CBH credentialing application is not present within the staff file.
- **1** = A CBH credentialing application is present, but has one (1) or more of the following deficiencies:
 - The CBH application present within the staff file is the wrong document for the particular employee (i.e., physician v. individual application).
 - The CBH application is not filled out in its entirety.
 - The CBH application is missing pages.
 - The CBH application is in an unreadable condition.
 - The CBH application lacks the signature of the employee and/or the date.
- **2** = A CBH credentialing application is present, complete, and filled out in its entirety.

Criminal History Clearance

- **0** = A criminal history clearance is NOT present within the staff file, is expired (e.g., two (2) years or older), unreadable, contains wrong information (e.g., date of birth, social security number, name), **or** has been altered in any capacity.
- **1** = A criminal history clearance is present, but has one (1) or more of the following deficiencies:
 - The criminal history clearance is present, but is not verified.
 - The criminal history clearance is present, but contains a criminal history that needs follow-up investigation that was not completed.
 - Request for the updated criminal history clearance does not contain a copy of the money order/check that was sent with the application.
 - Request for updated criminal history clearance does not have the date it was sent.
- **2** = A current, clear original criminal history clearance is present, **or** a verified copy.

D.E.A. Certification

- **0** = The D.E.A. certificate is not present within the staff file, is expired, **or** has been altered in any capacity.
- **1** = The D.E.A. certificate is present, but has one (1) or more of the following deficiencies:
 - The D.E.A. certificate is not verified.
 - The D.E.A. certificate is unreadable. **Note:** Poor copies of DEA certificates are not acceptable.
 - An original D.E.A. certificate could not be obtained, and there is no documentation citing the reason for the inability to review the original.
- **2** = A current, clear, original D.E.A. certificate **or** a verified copy is present.

Job Descriptions

- **0** = A job description is not present within the staff file, **or** the job description that is present does not accurately reflect the employee's current position.
- **1** = The job description is present, but has one (1) or more of the following deficiencies:
 - Both the employee and employer have not signed the job description on the date of hire, attesting to that fact that both parties recognize and understand the job responsibilities of the employee.
 - The job description is inaccurate.
- **2** = A job description is present, reflects the employee's current position, and is signed and dated by both employer and employee on the date of hire, or shortly following the change of job position (e.g., transfer, promotion, demotion).

Job Qualifications

- **0** = A staff member's documented credentials do not meet the minimum required qualifications of CBH, licensing bodies, and/or the provider's own standards.
- **2** = A staff member's documented credentials meet the minimum required qualifications of CBH, licensing bodies, and the provider's own standards.

License(s)/Certification(s)

- **0** = A license/certification is not present within the staff file, is expired, unsigned, unreadable, contains wrong information (e.g., name), **or** has been altered in any capacity.
- **1** = A license/certification is present, but has one (1) or more of the following deficiencies:
 - The license certification is not verified.
 - An original license/certification could not be obtained, and there is no documentation citing the reason for the inability to review the original.
- **2** = A current, clear, original license/certification **or** a verified copy is present.

In-Service Training

Mandatory In-Service Training

There are seven (7) mandatory trainings that are required within three (3) months of the date of hire and on an annual basis thereafter: Fire Safety & Prevention, Disaster Training, Suicide Precautions, Management of Escalation, Infection Control, Restrictive Procedures (if applicable), and Cultural Awareness. Clear and convincing evidence shall exist of their completion on a timely basis. Please see pg. 15 for example of clear and convincing standard.

For R.T.F. and day treatment facilities only: add Heimlich techniques, Behavioral Management, and First Aid to the required seven (7) mandatory trainings noted above (*Legal Reference:* 55 Pa Code §§ 3800.58(b)(1) – (6), and 3800.58(e)).

For substance abuse outpatient facilities only: add six (6) hours of HIV/AIDS training, and four (4) hours of tuberculosis, sexually transmitted disease and other health related topics training to the required seven (7) mandatory trainings noted above. (*Legal Reference:* 28 Pa Code §704.11(c)(1)).

- **0** = All of the mandatory trainings have not been completed within three (3) months of hire or evidence of completion of 'annual' retraining in the aforementioned subjects is absent.
- **1** = There is evidence of mandatory in-service trainings, but the documentation contains one (1) or more of the following deficiencies:
 - Mandatory in-services are being completed but are not included within each staff file in an individualized format.
 - There is evidence of mandatory in-service trainings being provided, but the documentation does not provide clear and convincing evidence of their completion. (*see Note below*).
 - A majority of the mandatory in-service trainings are completed, but not all of them.
- **2** = Clear and convincing evidence exists that **all** mandatory trainings have been completed within three (3) months of hire and, when applicable, retaken annually.

Ongoing In-Service Training

- **0** = There is no documentation concerning the completion of ongoing in-service training.
- **1** = There is evidence of ongoing in-service trainings, but the documentation contains one (1) or more of the following deficiencies:
 - There is evidence of the completion of ongoing in-service trainings, but there is not enough training hours to fulfill the provider training requirements.
 - There is evidence of ongoing in-service trainings being provided, but the documentation does not provide clear and convincing evidence of their completion.
- **2** = The staff file contains evidence of at least ten (10) hours of annual ongoing trainings. **Note:** This is in addition to the mandatory in-service training requirements.

Note: Clear and convincing evidence of the completion of trainings is equivalent to “irrefutable proof” that trainings were completed. If an original or a verified copy of a certificate of training is not available, clear and convincing documentation (a/k/a, “irrefutable proof”) verifying the completion of mandatory and/or ongoing in-service training should include:

- Employee’s name.
- Name of the employee’s department.
- Title of the training program.
- Name of training instructor.
- Date of the training.
- Number of training hours, including type of credit earned (e.g., C.E.C., C.E.U.).
- Description of training content.
- Employee’s signature
- Employer’s signature.

National Practitioner Data Bank

- **0** = The N.P.D.B. is not present within the staff file, is unreadable, **or** has been altered in any capacity.
- **1** = The N.P.D.B. is present, but has one (1) or more of the following deficiencies:
 - An original N.P.D.B. could not be obtained, and there is no documentation citing the reason for the inability to review the original.
 - The N.P.D.B. document is more than five (5) years old.
- **2** = A current, clear, original N.P.D.B. **or** a verified copy is present.

Performance Evaluations/Verification of Employment

- **0** = The staff file does not contain the requisite current performance evaluations and/or verification of employment from the previous two (2) employers.
- **1** = The staff file does contain performance evaluation(s) and/or verification of employment, but has one (1) or more of the following deficiencies:
 - Evaluations are illegible.
 - Evaluations are not dated.
 - Both supervisor and employee do not sign evaluations.
 - Evaluations are not completed per agency policy's time frame.
 - Evaluations are not recent (two (2) most recent years required).
 - Verification of employment is incomplete or is not signed and dated by the employer.
- **2** = Staff files contain the requisite number of current performance evaluations, **and/or** verification of employment from the past two (2) employers.

NOTE: Standardized agency telephone verification of employment may be used in lieu of written ones. Please ensure that staff members who conduct telephone verifications obtain the agency personnel's name and position from whom the information was obtained. Staff should then sign and date the telephone verification document as collector of the information. Please document any discrepancies between the application and the verification of employment.

Professional Liability Insurance (*Physicians only*)

- **0** = Professional liability insurance is not present, unreadable, or is out of date (expired).
- **1** = Professional liability insurance is present, but has one (1) or more of the following deficiencies:
 - The insurance policy does not possess the correct amount of insurance required: \$500,000/occurrence and \$1,500,000 aggregate coverage.
 - The copy of the insurance policy does not display the correct information.
- **2** = A clean copy of the professional liability insurance is present, with the name of the insured clearly displayed and the correct insurance amounts clearly indicated.

Resume/CV/Employment Application

- **0** = A resume/CV and/or application is NOT present within the staff file.
- **1** = A resume/CV/application is present, but has one (1) or more of the following deficiencies:
 - The resume/CV/application is unreadable.
 - The resume/CV/application does not list dates of past employment.
 - The resume/CV/application does not list dates of educational experience.
 - The resume/CV/application does not list conferred degrees.
 - The resume/CV/application does not list job position titles of past employment.
- **2** = A current resume/CV/application is present with a comprehensive, detailed history of past employment and education.

Note: It is recommended, but not required, that within one (1) year of date of hire, or within one (1) year of changing job positions, staff members update their resumes to reflect their current positions.

Determining the Staff Credentialing Score

The points for all of the staff credentialing files are totaled and the following formula is utilized to determine the staff score:

$$\frac{\text{Total Points Received}}{\text{Total Possible Points}}$$

Example: If all staff elements were applicable, the Agency can attain 336 total points* (100%). If the Agency received 270 points, then:

1. $270/336 = .80$
2. $.80 = 80\%$
3. $80\% = \text{Category 2}$

* Figure based on twelve (12) staff files reviewed in total.

<u>Total Score</u>	<u>Category</u>
81% and above	3
61% - 80%	2
60% or below	1

Policy and Procedure Requirements

All CBH Providers are required to maintain policies that meet national, state and discipline specific standards. Specific policies and procedures are mandated to protect the interests of all interested parties (e.g., the provider, the consumer, CBH) and to enable each provider to ensure compliance with their own established protocol.

All providers will maintain a policy and procedure manual that is reviewed annually, as evidenced by signatures of the agency's governing body and/or executive director. Each policy section discussing an issue should include the following sections: a general policy statement regarding the issue, a general purpose statement discussing the purpose of the policy, an applicability statement (i.e., who is the policy applicable to?), a listing of relevant statutes/laws/regulations that are applicable to the policy issue being discussed, followed by a detailed, clear, easy-to-read, step-by-step account of the protocol and procedure.

At a minimum, each provider will maintain the policies and procedures listed below, unless, a) a specific policy is not applicable to a particular level of service, or b) the provider is exempted by CBH due to specific circumstances (*See Exemptions Request section below*). The policy requirements below represent the **minimum** language that should be present within the policy, and serve **only** as guidelines in the development of said policies; however, they may not necessarily contain every element that could be found in a comprehensive policy. **Note:** Any variance found between State and CBH expectations will yield to the higher standard, unless otherwise determined.

Admissions/Intake policy: This policy should discuss, in great detail, and with great clarity, the process of admission/intake into the agency. This process should include the collection of the following documents (*where applicable*) during the admissions process: consents for treatment, Consumer Bill of Rights, PCPC, releases of information, a physical exam, immunization records and/or medical questionnaire. (*Legal Reference:* 55 Pa Code §5200.32(a)(2)).

- **0** = No policy exists, or the existing policy lacks three (3) or more of the requisite elements.
- **1** = The policy exists, but lacks two (2) of the following elements:
 - a. Policy language that states that the provider **will not discriminate** in the provision of services on the basis of age, race, creed, sex, ethnicity, color, national origin, marital status, sexual orientation, disability, or religion. (*Legal Reference:* 28 Pa Code §709.30(2)).
 - b. Policy language that discusses the **criteria for admission**. Criteria should, at a minimum include age, sex, physical and/or mental conditions, geographic requirements, nature of the drug and alcohol problem (*if applicable*) and any limitations (e.g., disabled, non-English speaking) that are applicable (*Legal References:* 28 Pa Code §709.91(4); 55 Pa Code §157.41(a)(1)).
 - c. Policy language stating that treatment of the consumer begins at the point of admission.
 - **Note:** The provider should identify when exactly admission becomes 'official.' Once established, the provider should clarify this established point in time to substantiate the above element

- d. Policy language that discusses, in great detail, and in simplistic terms, the process of admission/intake. This includes language that discusses the process of consumer orientation to the unit or program at the point of admission. Consumer orientation to the program may include, but is not limited to, a familiarization with the following: (*Legal References*: 28 Pa Code §709.91(2); 55 Pa Code §157.41(b)(1) & (2)).
 - A discussion of the criteria for admission/discharge, rules and regulations of the program, program hours of operation, fee schedule, emergency procedures, confidentiality issues, grievance and complaint procedures, on-call emergency protocol, tour of the program and any other relevant information that could be important to the consumer upon admittance to the program
 - e. Policy language that discusses the administration of evaluations/assessments.
 - **Note**: The provider should be advised that the admissions/intake policy should only briefly mention the administration of assessments (i.e., timeframes for completion and by whom) followed by a written cross-reference to the specific policy(s) that discuss this issue in detail.
 - f. Language that defines the making appointments time frame protocol for **routine**, **urgent**, and **emergency** admissions for intake and assessment.
 - **Note**: For **routine** admission, intake and admission must be scheduled in five (5) business days. For **urgent** admissions, it is within twenty-four (24) hours, and for **emergency** admissions, the process must begin within one (1) hour.
 - g. Policy language requiring family/significant other/parent/legal guardian (*when/if identified*) to be recognized, educated, and involved in all phases of treatment from admission through discharge and aftercare.
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Appointments/Rescheduling policy: (For outpatient services only.) This policy should reflect the protocol for scheduling ALL outpatient visits and missed or rescheduled appointments.

- **0** = No policy exists.
- **1** = The policy exists, but lacks one (1) of the following elements:
 - a. Policy language that discusses the protocol for scheduling all outpatient appointments (*not just the initial appointment*).
 - b. Policy language that discusses the protocol for dealing with missed appointments.
 - c. Policy language that discusses the process for rescheduling appointments.
 - d. Policy language that cites the **number of absences** a consumer may miss prior to the onset of administrative discharge procedures.
- **2** = The policy exists and contains all of the elements.

Assessment and Evaluation policy: The Provider will need to develop a policy with policy language that discusses the protocol and implementation of the consumer assessment process. If the Comprehensive Biopsychosocial Evaluation (*see below*) is not necessary, inappropriate or not utilized, then this Biopsychosocial Policy should be followed for all Substance Abuse programs, but only for those Mental Health programs in which it is not necessary for the client to be seen by a psychiatrist. Substance Abuse programs should cross-reference this Biopsychosocial Policy with the Psychiatric Evaluation Policy.

- **0** = No policy exists, or the existing policy lacks four (4) or more of the requisite elements.
- **1** = A policy exists which discusses the assignment of biopsychosocial assessments, but lacks three (3) of the following elements:
 - a. Policy language that requires assessments to be performed within the timeframe indicated by the Agency policy.
 - b. Policy language that requires assessments to reflect all identified presenting problems. Policy language should also exist that requires that presenting problems be written in a behaviorally defined manner.
 - c. Policy language that requires assessments to reflect both a comprehensive past and present history regarding the psychiatric, educational, maturational (*M.R. consumers and children only*), spiritual, nutritional, vocational/occupational, legal, sexual and social elements of a consumer's life.
 - d. Policy language that requires assessments to reflect a comprehensive medical history, including, at the minimum: current and past medications, other medical treatments the consumer may be receiving, current medical conditions of the consumer, and the food, environmental and drug allergies.
 - e. Policy language that requires assessments to reflect a comprehensive substance abuse history.
 - f. Policy language that requires assessments to reflect the consumer's strengths and any barriers to treatment.
 - g. Policy language that requires assessments to reflect the consumer's goals for treatment.
 - h. Policy language that requires assessments to contain a mental status exam.
 - i. Policy language that requires assessments to reflect both a consumer's history and current risk for aggression, abuse, and suicidality in an effort to determine potential harm to self and/or others.
 - j. Policy language that requires the assessment to contain current information on the consumer's support system.
 - k. Policy language that requires assessments to include a **FULL** DSM-IV five (5)-axes diagnosis.
 - l. Policy language that requires the assessments to contain documentation of initial discharge planning.
 - m. Policy language that requires biopsychosocial assessments to be reviewed and signed by a licensed supervising clinician (if not conducted by a licensed clinician).
 - n. Policy language that requires biopsychosocial assessments to be **LEGIBLE**.
- **2** = The policy exists and is not missing more than two (2) of the above elements.

Clinical Supervision policy: This policy will discuss the clinical supervisory responsibility within the organization. All providers will adhere to Pennsylvania state guidelines, as well as discipline specific regulations, in their provision of supervision to all clinical staff. The supervisory director of any multidisciplinary team is the individual who holds the highest degree of accountability by licensure, generally the psychiatrist. (*Legal Reference:* 28 Pa Code §704.9; 55 Pa Code §5200.23).

- **0** = No policy exists, or the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists, but lacks two (2) of the following elements:
 - a. Policy language that mandates that the provider will adhere to Pennsylvania state guidelines, as well as discipline specific regulations, to provide supervision to all clinical staff.
 - b. Policy language discussing, in great detail, the supervision of non-licensed staff and licensed staff:
 - **Note:** When discussing clinical supervision, the provider should **clearly differentiate** between the supervision of the two levels of staff, *including physicians*.
 - c. Policy language that discusses, in great detail, **how** clinical supervision is provided (e.g., interdepartmental meetings, group meetings, one-to-one meetings, consultations, rounds).
 - d. Policy language that discusses the frequency and duration of supervisory sessions and the method of documentation.
 - e. Policy language discussing the supervision of matriculated undergraduate and graduate students who are in accredited training programs in various mental health disciplines. (*if applicable*). (*Legal Reference:* 55 Pa Code §5200.22(j)).
 - f. Policy language discussing the training of students and the provider's need to conform to the legal and ethical standards set by the governing body in their field (e.g., A.P.A.) as well as State requirements.
 - g. Policy language that mandates that all trainees (students) will be treated with dignity and respect.
 - h. Policy language that mandates that the immediate supervisor will be ultimately responsible for trainee's (student) performance, and therefore, ultimately responsible for the consumer.
 - i. Policy language shall exist that requires:
 - The consumer to be made aware of the trainee's status.
 - The consumer to be able to identify the supervising clinician.
 - All clinical notes will be reviewed and signed by the supervising clinician.
- **2** = A policy exists which discusses the supervisory responsibilities surrounding the supervision of all clinical staff and is not missing more than one (1) of the above elements.

Comprehensive Biopsychosocial Evaluation (CBE) policy: This policy should define the contents of and the policy and procedure for the completion of the “Comprehensive Biopsychosocial Evaluation” (hereinafter, the “CBE”).

- **0** = No policy exists, or the existing policy lacks three (3) or more of the requisite elements.
- **1** = The policy exists, but lacks one (2) of the following elements:
 - Policy language that defines the Comprehensive Biopsychosocial Evaluation as a “complete gathering of ecological information through consumer interview, discussion with family members and/or caretakers, review of clinical records, and contact with collaborating agencies that leads to a biopsychosocial formulation, diagnoses, and treatment plan.”
 - Policy language that discusses the need for and implementation of the comprehensive biopsychosocial evaluation.
 - **For Mental Health services only:** Policy language that requires a licensed psychologist/psychiatrist to complete at least two (2) units of the evaluation.
 - Policy language that discusses the requirement that each evaluation must contain an accompanying document to the evaluation that specifically indicates the date and clock hours of the time spent on the evaluation by each evaluation participant and the corresponding LEGIBLE signature.
 - Policy language that requires the Comprehensive Biopsychosocial Evaluation to be LEGIBLE.
 - Policy language that sets forth the minimum baseline information to be captured on an evaluation (as discussed below) to be conducted and signed by a licensed professional.
 - **Chief Complaint/Presenting Problem:** Definition of the chief complaint in detail, **behaviorally defined**, and using the patient’s words to describe the problems. A description of problematic behaviors should be defined in terms of duration, frequency, intensity, and the context in which these behaviors occur.
 - **History of Present Illness:** This represents a chronologically organized history of current symptoms or syndromes, as well as recent exacerbations or remissions. It includes specific details related to previous treatments and responses to treatment. More importantly, it is necessary to define precipitating, aggravating, or other factors influencing the current situation.
 - **Developmental History:** The developmental history is important in understanding the consumer’s development to the present time and in the emotional significance of these facts as they relate to both the family and consumer. Important developmental information regarding conception, pregnancy, adoption, and infancy will help to identify any apparent changes or inconsistencies in the child’s developmental progress. Other areas include:
 - Physical development and medical history
 - School or work functioning
 - Substance abuse or dependence (including age of first use and age of continued use)
 - Emotional development and temperament
 - Peer relations
 - Family relationships
 - Conscience and values
 - Interests, hobbies, and talents
 - Unusual or traumatic events

- For children and adolescents, the developmental domains of physical growth, social, emotional, cognitive, and speech/language should be enumerated.
- **Behavioral Health Treatment History:** Description of specific behavioral health services including past behavioral health services provided and their impact on the consumer, including but not limited to:
 - Inpatient psychiatric hospitalization
 - Psychiatric partial hospitalization
 - Outpatient services (mental health and substance abuse)
 - Family-based mental health services
 - Pharmacotherapy (should include names, doses, and effectiveness)
 - Residential treatment facility services for psychiatric services
 - Behavioral Health Rehabilitation Services (BHRS)
 - Substance abuse treatment services (e.g., detoxification, residential rehabilitation, Methadone maintenance)
 - Specialized services (e.g., PTSD, Eating Disorders, Deaf and Hearing Services).

Note: It is important to provide a chronological summary of all past episodes of mental illness, including established diagnoses, pharmacological treatment, and periods of significant impairments or symptoms even if no treatment was sought or given. The treatment history should also include a consumer’s response to each previous service including effective interventions, ineffective interventions, adverse effects relevant to medications, length of abstinence (if substance use is involved), and salient features from past medical records.

- **Consumer’s Medical History Including Allergies.** This area includes a chronological summary of medical conditions or health problems, particularly if they are a source of emotional distress. This should include:
 - Non-psychiatric medical illness
 - History of significant head trauma, seizures, or CNS infections
 - Surgical history.
- **Family Medical History.**
 - History of psychiatric disorders in first and second degree relatives
 - History of treatment response
 - Incidence of cardiac and/or respiratory illness.
- **Social History:** This area should include the biological family’s history and background as well as the current composition of the “family.” This also includes a summary of living arrangements, relationships, role of relationships, and involvement with governmental social agencies, if any, as well as the status of involvement. Also included should be descriptions of:
 - Attachment patterns and coping challenges
 - Experiences with the parents’ own families of origin that may influence attitudes and behavior
 - Ethnic, cultural, and religious background
 - Involvement in other systems (e.g., child welfare, juvenile justice, criminal justice, placement history, mental retardation)
 - Governmental benefits (e.g., SSI, SSDI, Medicaid, Medicare).

- **Occupational and Educational:** Please identify the occupational and educational history of the consumer. In particular, identify the following:
 - For adults, it is important to note the sequence of jobs, current employment, reasons for job changes, job stressors, and military experience
 - For children and adolescents, it is important to describe the academic history, grades and performance in school, the child's view of school, the history of identified problems with learning or academic skills, including IEPs and, if available, functional behavioral analyses. Also described should be non-academic problems, such as the history of suspensions, expulsions, and truancy.
- **Consumer/Family Behaviors:** Evaluators must describe the behaviors exhibited during the consumer/caregiver interview. This includes the summary of the observation of interactions between child and family, between consumer and family members or significant others, and between consumer and evaluator.
- **Mental Status Exam:** (performed during face-to-face evaluation) which includes documentation of:
 - Current signs and symptoms of psychiatric disorders
 - Appearance and behavior
 - Mood and affect
 - Speech and language (rate, rhythm, flow of ideas, and pathological features)
 - Current thought and perceptions including, but not limited to: worries, concerns, thoughts, cognitive and perceptual symptom characteristics, level of consciousness, orientation, attention, and concentration
 - Motor behavior including activity level, coordination and presence of unusual motor patterns
 - Form and content of thinking and perception including presence of hallucinations, delusions, and thought disorder
 - Speech and language, including reading and writing
 - Overall intelligence
 - Attention and concentration
 - Memory
 - Neurological functioning (such as soft signs or cerebral dominance)
 - Judgment and insight
 - Preferred modes of communication (e.g., play, drawing, direct discourse).
- **Assessment of substance use:** Substance use includes: objective reporting of withdrawal symptoms using the CIWA Scale and the Narcotics Withdrawal Scale noted below, substance use within the last thirty (30) days and in the past year, treatment episodes within the last eighteen (18) months, medical complications related to substance use, and high risk behaviors related to substance use. Drug testing at the point of evaluation is important in ascertaining the level and type of substance use when determining level of care and verifying subjective information provided by the individual consumer. This is particularly important for the Crisis Response Centers, which have the capability to perform onsite urine drug screens and blood alcohol levels when assessing for substance abuse treatment. Please see the Clinical Care Guide for objective assessment and screening for substance use.

- **Collateral Information:** It is important to obtain information from other sources that will validate the issues being presented for treatment. This includes direct observation of behaviors in school, at home or other community settings (particularly for children and adolescents), review of clinical records from treatment sources, as well as evaluation, comparison, and interpretation of this information as it relates to the current evaluation.
- **Laboratory Tests:** Laboratory tests are important in validating medical conditions, identifying the use of substances by obtaining results from urine drug screen (UDS) and/or a blood alcohol level (BAL), and in determining the need for immediate medical interventions, including pharmacotherapy.
- **Data from Structured Tools:** Diagnostic instruments and structured assessment tools should be used, when indicated, to obtain objective information related to a number of areas including level of functioning, measurement of targeted behaviors, and determination of the presence of depressive symptoms of depression. For drug and alcohol issues, the Clinical Institute Withdrawal Scale for Alcohol (CIWA) and the Narcotics Withdrawal Scale are important for determining the severity of withdrawal symptoms.
- **Biopsychosocial Formulation:** The formulation interweaves the biological, psychological and social factors contributing to the consumer's difficulties with those that indicate potential success in a treatment setting. The comprehensive formulation leads to accurate diagnosis and to appropriate treatment planning. Components of the formulation include predisposing, precipitating, perpetuating, and protective factors. The individual's and family's personal strengths and community supports are important to consider in the formulation. A case formulation should include information on:
 - Adaptive strengths
 - Support(s) available in the individual's and family's environment
 - Stressors
 - Relationships
 - Prominent themes related to development, culture, ethnicity, gender, familial patterns, social class, and religious/spiritual issues
 - Medical issues that may pose an immediate risk to the individual, and in cases of pregnant women, the lack of prenatal care that may place the fetuses at significant risk
 - Special needs such as medical conditions, cognitive disabilities, primary caregivers with children, cultural issues/barriers, hearing and sight impairment, developmental disabilities
 - Environmental conditions that place an individual at risk of harm. Issues such as recent eviction, lack of permanent housing, living with others who may be using substances, or any other factors that may inhibit or support continued symptoms.
- **Diagnosis:**
 - **FULL** DSM-IV diagnosis (Axis I-V)
 - Provisional diagnoses may be used when there is a strong presumption that the full criteria will ultimately be met for a disorder, but that there is not enough information available to make a firm diagnosis.
- **Problem List/Recommendations for Intervention:** The Comprehensive Biopsychosocial Evaluation should identify specific recommendations for biological, psychological and social interventions that include the details of when, where, and who

will carry out the recommendations. The plan should clearly identify the scope of interventions to be provided and duration. Specific expectations and responses to those expectations should also be identified. This also includes any referrals that should be made. Reasons for referral include:

- Referrals should be made for additional medical consultation or psychological testing if indicated
 - Referrals for children and adolescents may include, but not be limited to: pediatric or medical consultations, such as physical examination, neurological evaluation, and evaluation of hearing, speech and language
 - For adults, referrals should be made for laboratory tests to rule out conditions that may have an affect on behaviors
 - Educational assessment, including psychoeducational testing through the School District, as needed
 - Referrals for child safety and welfare assessments, particularly an evaluation of home environments, should be done when indicated.
- **2** = A policy exists which discusses the implementation and expected contents of the CBE and is not missing more than one (1) of the above elements.

Comprehensive Biopsychosocial Re-Evaluation (CBR) policy: This policy should define the contents of and the policy and procedure for the completion of the “Comprehensive Biopsychosocial Re-Evaluation” (hereinafter, the “CBR”).

- **0** = No policy exists, or the existing policy lacks three (3) or more of the requisite elements.
- **1** = The policy exists, but lacks one (2) of the following elements:
 - Policy language that discusses the need for and implementation of the comprehensive biopsychosocial re-evaluation.
 - Policy language that requires the documentation of the clock hours (i.e., 12:00p-1:00p) of the re-evaluation within the document.
 - Policy language that discusses the requirement that each evaluation must contain an accompanying document to the evaluation that specifically indicates the date and clock hours of the time spent on the evaluation by each evaluation participant and the corresponding LEGIBLE signature.
 - Policy language that requires the Comprehensive Biopsychosocial Re-Evaluation to be LEGIBLE.
 - Policy language that sets forth the minimum baseline information to be captured on the re-evaluation (as discussed below) to be conducted and signed by a licensed professional.
 - **Clinical Justification for CBR:** The CBR must begin with a statement of clinical justification indicating the need for re-evaluation. Clinical justification could include, but not be limited to, a need for re-evaluation by the treating psychiatrist on a yearly basis; a need for an evaluation when some significant change has occurred; a request for continued BHRS or RTF service; a clinical need to have a psychiatrist evaluate the individual when the original CBE was completed by a psychologist. Clinical justification does not include addendums for BHRS or RTF service when the original CBE was insufficient.
 - **Demographic Information:** Note any changes in living arrangements or any other demographic information.

- **Mental Status Exam:** (performed during face-to-face evaluation) which includes documentation of:
 - Current signs and symptoms of psychiatric disorders
 - Consumer mood/affect/Appearance/behavior
 - Speech and language (rate, rhythm, flow of ideas, and pathological features)
 - Current thought and perceptions including, but not limited to: worries, concerns, thoughts, cognitive and perceptual symptom characteristics, level of consciousness, orientation, attention, and concentration
 - Motor behavior including activity level, coordination and presence of unusual motor patterns
 - Form and content of thinking and perception including presence of hallucinations, delusions, and thought disorder
 - Speech and language, including reading and writing
 - Overall intelligence
 - Attention and concentration
 - Memory
 - Neurological functioning (such as soft signs or cerebral dominance)
 - Judgment and insight
 - Preferred modes of communication (e.g., play, drawing, direct discourse).
- **Assessment of substance use:** Substance use includes: objective reporting of withdrawal symptoms using the CIWA Scale and the Narcotics Withdrawal Scale noted below, substance use within the last thirty (30) days and in the past year, treatment episodes within the last eighteen (18) months, medical complications related to substance use, and high risk behaviors related to substance use. Drug testing at the point of evaluation is important in ascertaining the level and type of substance use when determining level of care and verifying subjective information provided by the individual consumer. This is particularly important for the Crisis Response Centers, which have the capability to perform onsite urine drug screens and blood alcohol levels when assessing for substance abuse treatment. Please see the Clinical Care Guide for objective assessment and screening for substance use.
- **Collateral Information:** It is important to obtain information from other sources that will validate the issues being presented for treatment. This includes direct observation of behaviors in school, at home or other community settings (particularly for children and adolescents), review of clinical records from treatment sources, as well as evaluation, comparison, and interpretation of this information as it relates to the current evaluation.
- **Laboratory Tests:** Laboratory tests are important in validating medical conditions, identifying the use of substances by obtaining results from urine drug screen (UDS) and/or a blood alcohol level (BAL), and in determining the need for immediate medical interventions, including pharmacotherapy.
- **Data from Structured Tools:** Diagnostic instruments and structured assessment tools should be used, when indicated, to obtain objective information related to a number of areas including level of functioning, measurement of targeted behaviors, and determination of the presence of depressive symptoms of depression. For drug and alcohol issues, the Clinical Institute Withdrawal Scale for Alcohol (CIWA) and the Narcotics Withdrawal Scale are important for determining the severity of withdrawal symptoms.

- **Medical Issues:** A discussion of any changes in medical status including a listing of current medication with an accompanying discussion of its efficacy and any medication changes that occurred since the original CBE.
- **Treatment Plan Review:** The review of the current treatment goals including a clinical analysis of progress or lack thereof on treatment plan goals. The clinical analysis should include a discussion of the specific strategies that have proved to be effective as well as the identified strengths and barriers to treatment.
- **Updated Clinical Formulation:** Components of the formulation including precipitating, perpetuating and protective factors. The individual's and family's personal strengths and community supports are important to consider in the formulation. A case formulation should include information on:
 - Adaptive strengths
 - Consumer stressors
 - Relationships
 - Support(s) available in the consumer's/family's environment
 - Prominent themes related to development, culture, ethnicity, gender, familial patterns, social class, and religious/spiritual issues
 - Medical issues that may pose an immediate risk to the individual, and in cases of pregnant women, the lack of prenatal care that may place the fetuses at significant risk
 - Special needs such as medical conditions, cognitive disabilities, primary caregivers with children, cultural issues/barriers, hearing and sight impairment, developmental disabilities
 - Environmental conditions that place an individual at risk of harm. Issues such as recent eviction, lack of permanent housing, living with others who may be using substances, or any other factors that may inhibit or support continued symptoms.
- **Diagnosis:**
 - FULL DSM-IV diagnosis (Axis I-V)
 - Provisional diagnoses from the CBE should be resolved.
- **Problem List/Recommendations for Intervention:** The Comprehensive Biopsychosocial Re-Evaluation should identify updated recommendations for biological, psychological and social interventions that include details of when, where, and who will carry out the recommendations. The plan should clearly identify the scope of interventions to be provided, their duration and expected responses. Recommendations for additional referrals could include:
 - Additional medical consultation or psychological testing if indicated
 - Pediatric or medical consultations, such as physical examination, neurological evaluation, and evaluation of hearing, speech and language
 - Laboratory tests to rule out conditions that may have an affect on behaviors
 - Educational assessment, including psychoeducational testing through the School District (when indicated).
 - Child safety and welfare assessments (when indicated).
- **2** = A policy exists which discusses the implementation and expected contents of the CBR and is not missing more than one (1) of the above elements.

Confidentiality policy: Providers will have a comprehensive policy on confidentiality in accordance with all statutes and regulations, to the extent applicable (*Legal Reference:* 28 Pa Code §709.28). The policy will reflect that the provider is required to protect the confidentiality of all information in its records at all stages of collection, use, storage, disclosure, and destruction. Each provider’s employee has responsibility for safeguarding the confidentiality of consumer information (*See Appendix A*).

- **0** = No policy exists or the existing policy lacks three (3) or more of the requisite elements.
- **1** = The policy exists, but lacks two (2) of the following elements:
 - a. Policy language stating that the provider is required to protect the confidentiality of all information in its records at all stages of collection, use, storage, disclosure, and destruction.
 - b. Policy language that **defines a consumer record** to include all written clinical information, observations, reports or fiscal documents relating to prospective, present or former consumer, when the creation or retention of those documents is either required or authorized as a part of the operations. (*Legal Reference:* 55 Pa Code §5100.31(c)).
 - c. Policy language that discusses the purpose and importance of the confidentiality policy and that all employees are required to strictly adhere to the policy content.
 - d. Policy language which discusses what information is covered under the confidentiality policy (*as applicable*):
 - Demographic information.
 - Medical treatment information.
 - Mental Health treatment information.
 - Mental Retardation records/information.
 - Child abuse and neglect information.
 - Substance Abuse treatment information.
 - Contraceptive/Abortion services information.
 - Information received from county children and youth agencies.
 - Sexually transmitted diseases.
 - HIV information.
 - e. Policy language that deals with each of the above categories individually, citing the parties involved in the policy, the procedure, and the supporting statute citations.
 - f. Policy language that describes how the provider addresses the security and release of consumer records, and identifies the person(s) responsible for maintenance of consumer records. (*Legal Reference:* 28 Pa Code §709.28(a) (1)).
 - g. Policy language that discusses what staff members (by name or position) have access to consumer records and the methods by which staff gain access to records. (*Legal Reference:* 28 Pa Code §709.28(a)(2)).
 - h. Policy language that discusses the procedure in releasing confidential information in the case of a medical emergency. (*Legal Reference:* 28 Pa Code §709.28(e)(2); *see also* CBH Provider Manual §5.12).
 - i. Policy language stating that the confidentiality policy does not apply to documents that were public before the Provider received them, even if the documents now happen to be a part of the consumer’s file. (*Legal Reference:* 55 Pa Code §5100.31(h)).
- **2** = The policy exists and is not missing more than one (1) of the above elements. (CBH suggests that agencies integrate the Confidentiality Policy located in the CBH Credentialing Manual into their manuals to ensure compliance with CBH policy requirements.)

Consumer Rights policy: This policy will reflect the provider’s commitment to informing the consumer about his/her rights, and ensuring that the consumer **understands** those rights. Informing the consumer may include, but is not limited to, the posting of the consumer rights, having consumers sign off on the rights, and inclusion of the Bill of Rights within the orientation packet. (*Legal Reference:* 28 Pa Code §709.30).

- **0** = No policy exists or the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists regarding consumer rights, but lacks two (2) of the following elements:
 - a. Policy language guaranteeing the consumer’s access to information about all mental health and substance abuse opportunities/benefits in both inpatient and outpatient settings (*as applicable*).
 - b. Policy language that requires consumer rights be reviewed with the consumer (1:1) upon admission.
 - c. Policy language that requires a **statement of understanding** to be signed by the consumer on the Patient Rights document. (*Legal Reference:* 55 Pa Code §5100.55).
 - d. Policy language that discusses the requirement to discuss the consumer’s rights, responsibilities, and procedures to be followed regarding:
 - Access to treatment.
 - Confidentiality. (55 Pa Code §5100.31(b)).
 - Emergency procedures.
 - Complaints/Grievances process.
 - e. Policy language requiring the signed original Bill of Rights form, including the signature of a witness (i.e., staff), to be placed in consumer’s record and that the consumer be offered a copy.
 - f. Policy language requiring documentation of the reasons for failed attempts to obtain the consumer’s signature.
 - g. Policy language indicating the location within the facility where consumer rights are posted.

For children’s RTF services only:

- a. Policy language requiring upon admission that each child and available parent/guardian/custodian shall be informed in an easily understood manner (and in the primary language or mode of communication of the child and child’s parent/guardian/custodian) of the children’s rights, the right to lodge grievances without fear of retaliation, and the applicable consent to treatment protections as specified in 55 Pa Code §3800.19 (*Legal Reference:* 55 Pa Code §3800.31(a)(b)).
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Continued Stay/Concurrent Review policy

- **0** = No policy exists, or the existing policy lacks (2) or more of the requisite elements.
- **1** = A policy exists which discusses the protocol and documentation requirements regarding a continued stay, but lacks one (1) of the following necessary pieces of information:
 - a. Current five (5)-axes diagnosis.
 - b. Treatment progress (or lack thereof).
 - c. Medication information (*if applicable*).
 - d. Recommendations for continued care.
 - e. Anticipated problems/concerns for future compliance.
 - f. Mental Status Exam.
 - g. Special needs of consumer.
 - h. Discharge Planning.
 - i. Medical/Psychosocial problems.
- **2** = The policy exists and contains all of the requisite elements.

Criminal History/Child Abuse Clearance policy: All Providers will include a policy concerning the procedure for securing timely criminal histories and child abuse clearances (*when applicable*) for all direct care staff members.

- **0** = No policy exists, or the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists regarding the procedure for securing timely criminal histories and child abuse clearances (*when applicable*) for all direct care staff members, but lacks **two (2)** of the following elements:
 - Policy language requiring staff to undergo initial and ongoing criminal history clearance checks every two (2) years (*Legal References:* 35 P.S. §10225.502 (a)(1); *see* 18 Pa. C.S.A. §9109).
 - Policy language that requires any original child abuse and/or criminal history clearances submitted prior to hire, be dated no more than one (1) year prior to the hiring of a new employee. If either clearance is more than one (1) year old, new clearances will be obtained immediately (*if applicable*).
 - Policy language that discusses Act 80 that allows for the hiring of applicants on a provisional basis for 30 days (90 days for out-of-state applicants) until appropriate clearances have been received.

For Children’s Services only:

- Policy language that requires all prospective employees who reside outside of Pennsylvania to obtain a criminal history clearance from the FBI in addition to the Pennsylvania state criminal history (*Legal References:* 35 P.S. §10225.502(a)(2); *see* 28 U.S.C.A. §534(a)(1)). **Note:** This is available through ChildLine.
- Policy language that discusses the responsibility the provider has for keeping child abuse and criminal history clearances current on all non-clinical staff that have direct contact with children (*when applicable*, e.g., van drivers, kitchen staff).
- Policy language that references Act 33 requiring all staff that have direct contact with children to undergo initial and ongoing child abuse clearances every two (2) years.
- Policy language requiring an affirmation in writing (i.e., “Employee Disclosure Statement”) that an applicant’s clearance(s) will not include founded reports of child abuse (*when applicable*) and/or conviction of one or more of the following offenses within the past five (5) years: Criminal Homicide, Aggravated Assault, Kidnapping, Unlawful Restraint, Rape, Statutory Rape, Involuntary Deviant Sexual Intercourse, Indecent Assault, Indecent Exposure, Concealment of the Death of a Child Born out of Wedlock, Endangering the Welfare of Children, Dealing with Infant Children, Prostitution, Obscene or Other Sexual Materials, Corruption of Minors or Sexual Abuse of Children (*Legal Reference:* Child Protective Services Law, 23 Pa C.S.A. §6344(m)).

For Geriatric Services only:

- Policy language that requires all prospective employees who reside outside of Pennsylvania to obtain a criminal history clearance from the FBI in addition to the Pennsylvania state criminal history (*Legal References:* 35 P.S. §10225.502(a)(2); *see* 28 U.S.C.A. §534(a)(1)). **Note:** This is available through the Department of Aging.
- Policy language that states that if certain law convictions of statutory infractions are evidenced in the applicant’s clearance(s), then employment in a facility serving the geriatric population is forbidden (*Legal Reference:* 35 P.S. § 10225.503(a)(1)&(2)).
- Policy language that states the law convictions prohibiting employment within a geriatric service provider involve the Pennsylvania Controlled Substance, Drug, Device

and Cosmetic Act (*Legal Reference:* 35 P.S. §780-101) and the Pennsylvania Crimes Code (*Legal Reference:* 18 Pa C.S.A. §101).

- Policy language that cites the crimes within the Pennsylvania Crimes Code that deny employment: criminal homicide (§2501); aggravated assault (§2702); kidnapping (§2901); unlawful restraint (§2902); rape (§3121); statutory sexual assault (§3122.1); involuntary deviate sexual intercourse (§3123); sexual assault (§3124.1); aggravated indecent assault (§3125); indecent assault (§3126); indecent exposure (§3127); arson and related offenses (§3301); burglary (§3502); robbery (§3701); a felony, or two (2) or more misdemeanors under: theft by unlawful taking or disposition (§3921), theft by deception (§3922), theft by extortion (§3923), theft of property lost, mislaid, or delivered by mistake (§3924), receiving stolen property (§3925), theft of services (§3926), theft by failure to make required disposition of funds received (§3927), unauthorized use of automobiles and other vehicles (§3928), retail theft (§3929), library theft (§3929.1), theft of trade secrets (§3930), theft of unpublished dramas and musical compositions (§3931), or, theft of leased property (§3932); forgery (§4101); securing execution of documents by deception (§4114); incest (§4302); concealing death of child born out of wedlock (§4303); endangering the welfare of children (§4304); dealing in infant children (§4305); intimidation of witnesses or victims (§4952); retaliation of witnesses or victims (§4953); a felony promoting prostitution (§5902(b)); dissemination of obscene and other sexual materials (§5903(c)); admitting minor to show of obscene and other sexual materials (§5903(d)); corruption of minors (§6301); or, sexual abuse of children (§6312).
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Demographic Information policy: This policy should reflect the procedure for the collection of demographic data on each consumer. This policy does not have to stand-alone. The language may be incorporated within the context of the Admissions/Intake policy. Staff members authorized to collect such information should also be identified.

- **0** = No policy exists or the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists on the procedure for the collection of demographic data, but lacks two (2) of the following elements:
 - a. Policy language that identifies what staff member(s) is/are authorized to collect demographic information.
 - b. Policy language that discusses the minimum information to be collected: (all must be present)
 - Name
 - Address
 - Telephone number
 - Emergency contact
 - Marital Status (*if applicable*)
 - Gender
 - Ethnicity
 - Religion.
 - Date of Birth
 - Primary Language.
 - Social Security number.
 - Primary Care Physician
 - Insurance Information
 - Date and time of interview
 - Staff signature
- **2** = The policy exists, and is not missing more than one (1) of the above elements.

Discharge Policy: Against Facility Advice (AFA); Against Medical Advice (AMA); Administrative Discharge (AD): The policy should reflect the procedure when consumers leave treatment against medical/facility advice or have been required to leave for failure to adhere to agency policy.

- **0** = No policy exists or the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists which discusses the procedure for when consumers leave treatment against medical advice, but lacks two (2) of the following elements:
 - a. Language that discusses the consumer’s right to sign out of treatment (unless involuntarily committed).
 - b. Language that discusses the staff intervention strategies that are utilized when a consumer chooses to leave treatment (e.g., an evaluation for possible involuntary commitment, therapeutic discussion addressing consumer’s reasons reaching such a decision, consultation with psychiatrist).
 - c. Language that discusses the documentation that is required when a consumer leaves AFA/AMA.
 - **Note:** At a minimum, it is expected that a discharge summary and discharge note will be completed.
 - d. Language that discusses the requirement to fax a copy of the Significant Incident Report within 24 hours to the Quality Review Unit of CBH (as well as to fax a copy to your program’s funding source) of any AFA/AMA discharges.
 - **Note:** This **does not apply** to outpatient services, except Methadone maintenance services.
 - e. Language that discusses the requirement to consult with CBH clinical management prior to an administrative discharge.
 - f. Policy language that discusses the criteria for involuntary discharge/termination and/or administrative discharges. (*Legal Reference:* 28 Pa Code §709.91(4)).
 - g. Policy language that requires provider’s to notify the consumer, in writing, of a decision to involuntarily terminate the consumer’s treatment at the provider’s agency. The notice shall include the reason for termination. (*Legal Reference:* 28 Pa Code §709.33(a)).
- **2** = A policy exists, and is not missing more than one (1) of the above elements.

Discharge Documentation policy: CBH has identified three components to document the discharge of a consumer. Providers are expected to document a discharge/transfer summary, a discharge/transfer note, and an aftercare plan. Providers are encouraged to develop documentation procedures that streamline the required elements while still meeting the expectations of each component as follows:

Discharge Note

- **0** = No policy exists, or the existing policy lacks two (2) or more of the following elements.
- **1** = A policy exists, but lacks one (1) of the following elements:
 - a. Policy language that requires a discharge note to be written within the progress note section discussing the termination of the therapeutic process
 - b. Policy language requiring discharge notes to describe the consumer’s behavior and attitude upon discharge.
 - c. Policy language requiring discharge notes to document the consumer’s destination and mode of transportation upon discharge. **Note:** Mode of transportation is for inpatient services only.
 - **Note:** “Mode of transportation” is for inpatient services only.
 - d. Policy language requiring discharge notes to discuss treatment outcomes.
 - e. Policy language requiring discharge notes to affirm that the consumer is informed and aware of any follow-up appointments.
- **2** = The policy exists, and is not missing any of the above elements.

Aftercare Planning [*Legal References:* 55 Pa Code §157.22(b); 55 Pa Code §157.23(a); 55 Pa Code §5221.33(5)(iii)].

- **0** = No policy exists, or the existing policy lacks two (2) or more of the following elements.
- **1** = A policy exists, but lacks one (1) of the following elements:
 - a. Policy language that discusses the process by which the provider follows up on the consumer after discharge **and** how the consumer is informed of this process.

As to the content of the Aftercare Plan:

- b. Policy language requiring aftercare plans to include all the critical problems of the consumer.
 - c. Policy language requiring aftercare plans to obtain the signature of the consumer.
 - d. Policy language requiring aftercare plans to describe the consumer’s method for obtaining their medications (*if applicable*) upon discharge.
 - e. Policy language that requires a consumer’s discharge follow-up appointments appear on the aftercare plan.
 - f. Policy language requiring aftercare plans to identify appropriate living arrangements.
 - **Note:** For inpatient services only.
 - g. Policy language requiring aftercare plans to contain the development of a crisis plan.
- **2** = The policy exists, and is not missing any of the above elements.

Discharge/Transfer Summary

- **0** = No policy exists or the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists which discusses the discharge summary, but lacks two (2) of the following elements:
 - a. Policy language that specifies the **purpose of** the discharge/transfer summary (e.g., To provide accurate discharge status information to aftercare providers in a timely manner).
 - b. Policy language that discusses the types of discharges, **in general**, that may occur within the Provider's treatment facility (e.g., successful completion of treatment, medical leave, therapeutic leave, transfer to another level of care, Against Medical Advice/Facility Advice or Absent Without Leave, and Involuntary Discharge).
 - c. Policy language specifying that **within one (1) week of discharge**, there should be entered into the consumer's record a discharge or transfer summary. (*Legal Reference*: 28 Pa Code §709.93(10)).
 - d. Policy language that requires the attending psychiatrist and/or clinical director to review and co-sign the discharge/transfer summary.

As to the content of the Discharge Summary: (*Legal Reference*: 28 Pa Code §709.93(10)).

- a. Reasons for Treatment.
 - b. Initial and Final five (5)-axes diagnosis. (*Legal Reference*: 55 Pa Code §1101.51(e)(1)(iv)).
 - c. Services offered.
 - d. Summary of treatment progress (or lack thereof).
 - e. Medication information (*if applicable*).
 - f. Recommendations for aftercare.
 - g. Special needs of the consumer.
 - h. Consumer's status or condition upon discharge.
 - i. Medical/Psychosocial problems of consumer.
 - j. Anticipated problems/concerns for future compliance.
 - k. Primary Care Physician is identified (*if known*).
- **2** = The policy exists and is not missing **more than one (1)** of the above elements.

Transfer Summary (Inpatient Only)

- **0** = No policy exists or the existing policy **lacks (2) or more** of the requisite elements.
- **1** = A policy exists which discusses the minimum information to be reflected in a clinical chart following the transfer of a consumer, but lacks **one (1)** of the following elements:
 - a. A physician order was completed for transfer.
 - b. Consumer was informed as to the reasons for transfer.
 - c. Consumer response to the transfer was recorded.
 - d. Family/support network of consumer is notified of transfer. (*consumers <14 only.*)
 - e. Transfer note includes:
 - Date, time, and method of transfer.
 - Medications, if any, administered in the past four (4) hours.
 - Condition of consumer.
- **2** = The policy exists and contains **all** of the requisite elements.

Employee Orientation policy: All Providers will have a detailed policy regarding the implementation of employee orientation for all new employees. Each Provider will have a structured educational program of orientation for all new staff that are involved in direct consumer contact, or are supervisors for direct care staff. (*Legal Reference:* §709.26(b)(3)).

- **0** = No policy exists or the existing policy lacks two (2) or more of the requisite elements.
- **1** = A policy exists which discusses, in great detail, the structured educational orientation procedure for all new staff members, but lacks one (1) of the following elements:
 - a. Policy language that discusses in specificity the employee orientation content and attendance requirements (**Note:** Specific mention of the CBH mandatory in-service trainings is required).
 - b. Policy language that discusses the term of orientation (e.g., 1 week, 30 days, 90 days, 120 days).
 - c. Policy language that mandates that staff will receive orientation for the entire agency **and** the specific unit to which they are assigned.
- **2** = The policy exists and contains all of the above elements.

Employment Sanctions policy: The provider will establish a policy describing the mechanism for reporting criminal convictions, reports of child abuse and/or license/certification suspension/revocation to the provider, pre-employment and throughout the term of hire.

- **0** = No policy exists or the existing policy lacks two (2) or more of the requisite elements.
- **1** = A policy exists which discusses the duty of staff to report sanctions (e.g., criminal arrests, convictions, license suspensions/revocations, child abuse reports) taken against them to the provider agency or affiliate, but lacks one (1) of the following elements:
 - a. Policy language that discusses the duty all staff have to inform the provider about criminal convictions, child abuse reports and license suspensions and/or revocations at the time of hire as well as throughout the entire duration of employment.
 - b. Policy language that addresses the process the provider will use to inform staff when information received during credentialing contradicts with information provided by the employee.
 - c. Policy language that mandates that staff members will be given an opportunity to explain or correct misinformation in the file, subject to clearly delineated sanctions explained in the provider policy and addresses in great specificity the procedure the staff member will use to respond to the conflicting information.
 - d. Policy language that discusses the provider's disciplinary action(s) for an employee's failure to report the aforementioned events.
- **2** = The policy exists and contains all requisite elements.

Incident/Occurrence Policy: The provider will have a policy that addresses the provider’s efforts towards identification, reporting, management, and investigation of all reportable significant incidents involving a consumer.

- **0** = No policy exists, or the existing policy is lacking three (3) or more of the requisite elements.
- **1** = A policy exists regarding the provider’s efforts towards identification, reporting, management, and investigation of all reportable incidents, but lacks two (2) of the following elements:
 - a. Policy language that defines an unusual or significant incident as: “Care or treatment that is not routine and is inconsistent with the standards of practice, or the operation of a network provider, and that has resulted in injury or potential harm to a BHS consumer.” (*See, CBH Provider Manual, 12/99, Quality Management, Section 5.3*)
 - b. Language that indicates that this policy is applicable whenever a provider reports a significant incident involving an adult or child BHS consumer of mental health and drug and alcohol services, whether they are:
 1. CBH members receiving in-plan services, or
 2. County-funded individuals receiving supplemental funding through the Office of Mental Health, or the Coordinating Office of Drug and Alcohol Programs, including those served by the Behavioral Health Special Initiative (BHSI).
 - c. Policy language that requires the provider to fax a copy of the incident report to the BHS within 24 hours of occurrence, via the Significant Incident Report form. One copy should be sent to the **Quality Review Unit of CBH**, and the second copy to the program’s funding source: OMH Adult Unit, OMH Children’s Unit, or CODAAP (*whichever is applicable*). **Note:** This action usually precedes an investigation.
 - d. Language that requires providers to report significant incidents involving the physical, sexual abuse and/or neglect of children to the State and are required to report by telephone to the Commonwealth’s CHILdline at (800) 932-0313.
 - e. Policy language that requires the provider to notify any reportable incidents to the consumer’s parent/legal guardian or custodian (*when applicable*) unless precluded by court order or applicable confidentiality standards.
 - f. Policy language that requires the provider to report a missing person who is ‘at-risk’ to the Mental Health Delegates, by faxing a Missing Person Report Form to (215) 732-2508.
 - g. Policy language that requires medical emergencies to be documented and to include date and time of incident, along with date and time of physician notification.
 - h. Policy language that cites a list of reportable incidents that fall within the scope of the policy. The following list is a non-exhaustive list of reportable incidents as outlined in the CBH Provider Bulletin, dated November 11, 2002 (*See also, CBH Provider Manual, §5.2(a)*):

Reportable Incidents include, but are not limited to, the following:

- Death of a consumer.
- Homicide committed by a consumer/consumer who is in service or has been discharged within thirty (30) days.
- Suicide attempt requiring medical intervention or hospitalization.
- Act of violence with injury requiring emergency treatment, by or to a consumer/consumer (*MH only, if by a consumer*).
- Adverse drug reactions to medication administered by provider that requires medical attention.

- Alleged or suspected abuse (physical, financial, sexual) of or by a consumer/consumer (*MH only*).
- The absence of a child from the premises for eight (8) hours or more without staff permission, or twenty-four (24) hours for ‘at-risk’ adults (**Note: Inpatient services only**).
- Neglect that results in serious injury or hospitalization (*MH only*).
- Misuse of consumer’s funds.
- An outbreak of a serious communicable disease (as defined in 28 Pa Code §27.2 – relating to reportable diseases).
- Arrest (**Note: Excludes involuntary commitments (302’s)**).
- Fire or serious property damage at the site where behavioral health services are delivered.
- All **non-routine discharges** at any type of **inpatient** service (e.g., administrative/involuntary discharges or leaving a facility against medical or facility advice (AMA, AFA)).
- **For R.T.F. and day treatment services:** refer to 55 Pa Code §3800.16 for a list of reportable incidents.
- **2** = The policy exists, **and** is not missing **more than one (1)** of the above elements.

Individual Service Plan (ISP) Development policy: This policy describes the development of the Individual Service Plan (*For RTF and Day Treatment services only*).

- **0** = No policy exists or the existing policy lacks **three (3) or more** of the requisite elements.
- **1** = A policy exists that describes the development of the ISP, but lacks **two (2)** of the following elements:
 - a. Policy language that requires the ISP to be developed within thirty (30) calendar days of admission to the program.
 - b. Policy language that discusses how the youth/parent/legal guardian/representative of the placing agency, as well as others invited, are involved in the ISP planning process.
 - c. Policy language that requires ISPs to be signed by all participants (including the administrator of the facility) involved in the development of the ISP.
 - d. Policy language that requires the provider to offer a copy of the initial and amended ISP to the parents or guardian and the placing agency and shall make the ISP a part of the child’s record.
 - e. Policy language that requires the ISP to be reviewed every four (4) months and revised, if necessary.
 - f. Policy language that requires the ISP to follow CASSP principles and to contain:
 - Measurable, time-limited, individualized strength-based service goals for each level of service, along with evaluation of the youth’s skill level for each goal.
 - Monthly documentation of goal progress.
 - Specification of specialized activities or services to be provided, arranged for, or coordinated by the facility as well as the methods for measuring accomplishment.
 - A restrictive procedures plan, if necessary.
 - A schedule of the child’s visits by or with parents or guardian.
 - Anticipated duration of stay, **along with initial discharge or transfer plan.**

- Identification of the staff responsible for, and their role in implementing, the ISP and methods of assessing progress.
- Signature of consumer and legal guardian.
- g. Policy language stating that the Provider is not required to develop an ISP for a child receiving emergency placement service
- **2** = The policy exists and is not missing **more than one (1)** of the above elements.

Informed Consent policy: All providers will have a policy that discusses the attainment of informed consent from consumers for treatment in general, **AND**, informed consent for each and every medication prescribed during the course of the therapeutic process. The policy will state that each person is **entitled** to clear information about his/her behavioral healthcare and possible treatment options, including medications. Each provider will comply with State statutes and regulations relating to consent for treatment, as applicable. (*Legal Reference:* 28 Pa Code §709.91(4)).

- **0** = No policy exists, or the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists which discusses the policy and procedure surrounding receiving informed consent for treatment from a consumer, but lacks two (2) of the following elements:
 - a. Policy language indicating that as a part of informed consent, each patient has a right to clear information about his/her behavioral healthcare and possible treatment options, including the prescription of medications.
 - b. Policy language requiring an explanation of the proposed intervention(s), treatment(s), and potential for the implementation of medication(s) during the therapeutic process, as well as, any potential benefits, risks and side effects due to the suggested therapeutic regimen. (*Legal Reference:* 55 Pa Code §5100.73(a)).
 - c. Policy language requiring the disclosure of the consumer’s right (*to the extent permitted by law*) to refuse treatment interventions, including medications.
 - d. Policy language that designates the person(s) responsible for supplying informed consent information to the consumer.
 - **Note:** The physician or person who is responsible for providing treatment is responsible for obtaining consumer consent.
 - e. Policy language that requires a copy of the informed consent to be made a part of the consumer’s record, and the consumer to be offered a copy of this document. (*Legal Reference:* 55 Pa Code §5100.73(b)).
 - f. Policy language requiring the provider to supply a translator when necessary.

Informed consent for the Use of Medications

- g. Policy language that discusses how the Provider obtains informed consent from the consumer for the prescription of any medication during the therapeutic process.
 - **Note:** A medication-specific informed consent document is no longer mandatory. In the absence of one, informed consent for medications can now be accomplished by having the physician document the information noted below following any initial prescription, change, or discontinuation in medication within the medication progress notes. To provide evidence of informed consent, medication progress notes should contain the following information when a medication is prescribed:
 - Specific name of medication is given to the consumer.
 - Evidence that the risks, benefits, and side effects have been discussed to the consumer.
 - Evidence that reasons were given to the consumer as to why there was an initial prescription, increase, decrease, or discontinuation of a medication.

- Evidence that the consumer agrees to the usage of the medication prescribed and understands all of the information noted above.
- Legible physician’s signature following the entry.

Informed consent for the Use of Methadone

h. Policy language indicating that before Methadone may be administered to a consumer as treatment an “informed, voluntary consent” must be obtained (*Legal Reference*: 28 Pa Code §715.12). Policy language shall require a written consent and must contain a list of specific items that must appear in writing on said consent:

- That Methadone and LAAM are narcotic drugs that can be harmful if taken without medical supervision.
- That Methadone and LAAM are addictive medications and may, like other drugs used in medical practices, produce adverse results.
- That alternative methods of treatment exist.
- That the possible risks and complications of treatment have been explained to the consumer.
- That Methadone is transmitted to the unborn child and will cause physical dependence.

- **2** = The policy exists, **and** is not missing more than one (1) of the above elements.

In-Service (mandatory and ongoing) policy:

Mandatory In-service Training

All providers will have a policy that discusses the requirement of employees to participate in the CBH mandatory trainings during the first three months of employment **and** annually thereafter. (*Legal Reference*: §709.26(c)(1)(2)(3)(4)). This policy may be made a part of the Employee Orientation policy (*see above*).

- **0** = No policy exists, or the existing policy lacks **three (3) or more** of the following elements.
- **1** = A policy exists which mandates that staff members are to complete the CBH mandatory in-service trainings, but the language lacks **two (2)** of the following trainings:
 - a. Policy language that delineates the following trainings:
 - Fire Safety & Prevention.
 - Suicide Precautions.
 - Management of Escalation.
 - Restrictive Procedures (if applicable).
 - Infection Control/Universal Precautions/Blood borne Pathogens.
 - Cultural Awareness.
 - Disaster Training.

For R.T.F. and Day Treatment services only:

- Behavioral Management, Heimlich techniques, First Aid and CPR. (*Legal Reference*: 55 Pa Code §3800.58(b)(1)-(6) & (e)). **Exception:** If CPR training is validated for more than one (1) year, the annual requirement is waived. (*Legal Reference*: 55 Pa Code §3800.58(e)).

For Substance Abuse Outpatient facilities only:

- Six (6) hours of HIV/AIDS training, and four (4) hours of tuberculosis, sexually transmitted disease and other health related topics training. (*Legal Reference:* 28 Pa Code §704.11(c)(1)).
 - b. Policy language that states that the trainings will be completed within three (3) months of hire, and then annually thereafter.
 - c. Policy language that discusses how mandatory in-service trainings are documented within the staff files.
- **2** = The policy exists and is not missing **more than one (1)** of the above elements.

Ongoing In-service Training

All providers will have a policy discussing the provision of ongoing in-services/trainings for all staff members, and the minimum number of training hours, in accordance with State regulations, required by each job position. (*Legal References:* 28 Pa Code §709.26(c)(1)(2)(3)(4); 28 Pa Code §704.11(a)).

- **0** = No policy exists.
- **2** = A policy exists which discusses the Provider's protocol for the provision of trainings and continued education to all staff members (i.e., a discussion regarding the development of the annual training plan and its implementation), and the required hours per year which will be fulfilled for each discipline or position within the Agency. **Note:** Specific reference must be made to the CBH mandatory trainings as being in addition to the required ongoing in-service training hours.

For Residential and Day Treatment facilities: The providers are reminded that forty (40) hours of ongoing in-service training is required annually relating to the care and management of children. (*Legal Reference:* 55 Pa Code §3800.58(d)).

Management of Escalation policy: The policy will reflect the philosophy and therapeutic interventions utilized for management of escalating behavior. The policy will delineate the techniques considered standard in the behavioral health industry.

- **0** = No policy exists.
- **1** = A policy exists which discusses the significance of identifying and managing escalating behavior but lacks one (1) of the following elements:
 - a. Policy language that mandates that training is mandatory within the first three (3) months of hire, and that staff will attend yearly updates.
 - b. Policy language that indicates the source of training (e.g., Crisis Prevention Institute, Inc.). **Note:** The Provider should identify the philosophy of de-escalation that is taught and authorized to be followed within the agency.
 - c. The policy manual should contain illustrations that reflect and language that describes agency-approved techniques and procedures considered standard in the behavioral health industry, as reflected by the adopted source of training, noted above.
- **2** = The policy exists and contains all of the requisite elements.

Medication Management policy: Providers shall have a written policy regarding the storage, administration and documentation of all medications (including P.R.N. medications) within the context of a therapeutic environment, as applicable (*Legal Reference:* 28 Pa Code §709.32(c); 55 Pa Code §5200.42(b)). Those who furnish pharmaceutical services shall comply with all applicable Federal, State and local ordinances, statutes and regulations regarding the storage, administering or dispensing of medication (*Legal Reference:* 28 Pa Code §709.32(a)). The following elements represent the minimum information that will be included in the policy's construction:

Medication Storage (*Legal Reference:* 28 Pa Code §709.32(2)).

- **0** = No policy exists, or, the existing policy lacks **three (3) or more** of the requisite elements.
- **1** = A policy exists delineating the procedure surrounding the storage, administration, and documentation of medications, but lacks **two (2)** of the following elements:
 - a. Policy language requiring that all prescription and over-the-counter medications will be kept in their original containers **and** will be stored separately and locked.
 - b. Policy language requiring that all medications that need to be refrigerated will be stored in a locked container.
 - c. Policy language requiring all medications to be stored under proper conditions of cleanliness, temperature, moisture and light.
 - d. Policy language requiring a current agreement with a local pharmacy to provide 24-hour delivery of medications on file. **Note:** Inpatient services only.
 - e. Policy language that calls for the inspection of all drug storage areas. This should include what is to be verified through the inspection, who inspects, how often, and the documentation requirements. These inspections should be done at least quarterly to ensure these areas are maintained in compliance with federal, state and local regulations (*Legal Reference:* 28 Pa Code §709.32(3)).
 - f. Policy language that describes the system for medication accountability and control. This should include who is authorized to remove drugs from the storage areas and the means of accountability for all stored drugs (*Legal Reference:* 28 Pa Code §709.32(4)).
 - g. Policy language that describes the process by which medications are checked for dates of expiration (*Legal Reference:* 28 Pa Code §709.32(3)).
 - h. Policy language that discusses the mechanism for notification of a drug recall by the pharmacy of choice to the Provider. Communication of that drug recall within the Agency should be described.
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Medication Administration: Under Pennsylvania law, the only persons legally permitted to administer medication (controlled substances) are physicians, physician's assistants, certified registered nurse practitioners, registered nurses, licensed practical nurses, and licensed paramedics. (*Legal Reference:* 28 Pa Code §709.32(c)(1)).

- **0** = No policy exists, or, the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists delineating the procedure on the administration of medications, but lacks **two (2)** of the following elements:
 - a. Policy language stating that the safe prescription and administration of medications is monitored as a component of the Provider's quality management efforts.
 - b. Policy language mandating that medications will only be administered to whom they are prescribed.

- c. Policy language requiring medication errors to be reported and recorded, and an explanation of this process (*Legal Reference*: 28 Pa Code §709.32(7)).
 - d. Policy language should discuss the responsibility of the Provider to notify the CBH Quality Review Unit of the Provider Network Operations Department of adverse medication reactions according to the terms of the required Incident Reporting policy (*See Behavioral Health System Provider Bulletin dated 11/06/02*).
 - e. **For children’s services only**: Policy language requiring the prescribing physician, parent/legal guardian/custodian to be notified of an adverse reaction.
 - f. Policy language that clearly delineates the types and classifications of medications that may be administered by those qualified non-licensed staff members.
 - g. Policy language requiring staff to complete a medication administration course every two (2) years. **Note**: This excludes physicians and nurses.
 - h. Policy language mandating staff to complete and pass a Department of Health approved course on diabetes education within the past twelve (12) months before they may administer insulin injections (*if applicable*). **Note**: This excludes physicians and nurses
 - i. Policy language that describes the training that ALL staff receive regarding the common side effects of medications found within the Agency approved formulary. **Note**: This excludes physicians and nurses
- **2** = The policy exists, and is not missing more than one (1) of the above elements.

Medication Documentation: The policy language will discuss the procedure regarding the maintenance of proper medication documentation. Policy language discussing medication documentation should address physician’s notes, physician’s orders, and medication logs (**Legal reference**: 28 Pa Code § 709.93(a)(2)). The language will delineate the minimum amount of information to be collected and documented:

- **0** = No policy exists or the existing policy is lacking three (3) or more elements.
- **1** = A policy exists delineating the procedure regarding the appropriate documentation on medication orders, logs and notes, but lacks two (2) of the following elements:
 - a. **General**: Medication documentation policy will contain language requiring that:
 - All medication entries, including signatures, will be legible. (*Legal reference*: 55 Pa Code § 1101.51(e)(1)(1)).
 - Consumer allergies will be noted on the cover of the chart **and** within the clinical record. **Note**: where applicable, this includes the Kardex.
 - Medication Kardex will be maintained according to hospital policy (**Note**: Inpatient and RTF services only.) All elements identified in the hospital policy will be present and recorded as required.
 - Upon notification to the doctor of an adverse reaction, the date, time of notification of the physician, physician’s response, and verbal orders (if applicable) will be recorded (*Legal reference*: 55 Pa Code § 3800.186).

For all self-administered medications, the log will include:

- Consumer’s name
- Date
- Time
- Dosage
- Name of prescribing physician
- Signature of Monitor and consumer.

Note: Applicable to Adult Residential Services, RTF, and Partial Treatment Services only.

- b. Medication orders or logs: Policy language that requires all entries to contain the following in their entirety:
- Consumer's name.
 - Date of order.
 - Name(s) of medication.
 - Dosage of medication.
 - Legible physician's signature (if verbal order, will be signed as required by hospital policy).
 - Route of Administration.
 - Frequency of medication.
 - Reason medication is given (PRN only.)
- c. Physician's monitoring notes: Policy language requiring that notes contain:
- Specific name of medication is disseminated to the consumer.
 - Evidence that the risks, benefits, and side effects (adverse reactions) have been disseminated to the consumer and what to do in emergency situations.
 - Evidence that reasons were given to the consumer as to why there was an increase, decrease, initial order, or discontinuation of a medication. This must be done in a way that is understandable to the consumer.
 - Evidence that the consumer agrees to the usage of the medication prescribed and understands all of the information noted above.
 - Legible physician's signature following the entry
- **2** = The policy exists and is not missing more than one (1) of the above elements.

P.R.N. Medication Documentation: For those utilizing P.R.N. medications within the therapeutic environment, a policy shall exist that discusses the documentation requirements for the utilization of P.R.N. medications within the clinical chart. Policy language must also exist that discusses the requirement that a progress note be written for each PRN medication administered.

- **0** = No policy exists, or, the existing policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists which delineates the procedure for the documentation of P.R.N. medication information, but lacks two (2) of the following elements:
 - Policy language that discusses the minimum requirements for a physician order. The minimum required documentation contains ALL of the following:
 - a. Name of medication.
 - b. Dosage of medication.
 - c. Route of Administration.
 - d. Frequency of medication.
 - e. Reason medication is given.
 - f. Legible physician's signature (if verbal order, will be signed as required by hospital policy)
 - Policy language that requires the intervention strategies utilized prior to P.R.N. medication administration to be documented.
 - Policy language that requires the progress notes to reflect the symptoms that lead to the order for and administration of PRN medication(s).
 - Policy language requiring consumer behavior to be is described in the progress note, including response(s) to PRN medication.
 - Policy language requiring PRN medication to be recorded on the kardex (*where applicable*) and that it will be in compliance with documentation requirements per Agency policy, along with RN/Graduate Nurse's initials and/or signature.

- Policy language requiring the documentation of the maintenance of PRN medications to be LEGIBLE.
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Medical Information policy: This policy will discuss the policy and procedure regarding the collection and documentation of a consumer's medical/personal health history. The provider is to ensure that **ALL** methods of collecting medical/personal health information are discussed

- **0** = No policy exists, or, the existing policy lacks two (2) or more of the requisite elements.
- **1** = A policy exists which delineates the procedure for the collection and documentation of the minimum medical information, but lacks one (1) of the following elements:
 - Medical condition of consumer.
 - Current medications (Including drug name, dosage, compliance with regime and prescribing physician).
 - Other medical treatments the consumer is receiving.
 - Drug, food, and environmental allergies.
 - Other pertinent health-related information.
 - Primary care physician, *if known*.
- **2** = The policy exists and contains all of the above elements.

On-Call Emergency Protocol policy: The provider will have an on-call emergency protocol that addresses the consumer's ability to access the agency/independent provider during non-business hours (*outpatient services only*) [*Legal Reference: 55 Pa Code §5221.23(a)*].

- **0** = No policy exists.
- **1** = A policy exists that discusses the on-call emergency protocol, but lacks one (1) of the following elements:
 - a. Policy language that discusses the consumer's ability to access the treatment provider during non-business hours (e.g., *beeper system, answering system*).
 - b. Policy language that discusses how the consumer is informed about the provider's on-call emergency procedure.
 - **Note:** This should be a part of the consumer's initial orientation to the program.
 - c. Policy language that identifies the names of providers/agencies utilized for emergency services. Addresses and phone numbers should be included within the policy.
- **2** = The policy exists and contains all of the above elements.

Physical Plant Standard Policy: Every provider is expected to maintain a safe, secure, and comfortable treatment setting in which to serve its members (*Legal Reference:* §709.27).

- **0** = No policy exists, or, the existing policy lacks three (3) or more of the requisite elements.
- **1** = The policy exists, but lacks two (2) of the following elements:
 - a. Policy language that states that the provider will maintain a safe, secure, and comfortable treatment setting in which to serve its members
 - b. Policy language that discusses the process for internally assessing compliance with its established standards and making improvements where necessary.
 - c. Policy language that references that the provider will conduct regular site visits at all treatment programs in order to inspect the physical environment, therapeutic milieu, level of staffing (i.e., staff to patient ratio), and other features relevant to the care of consumers.
 - d. Policy language that states that the provider will comply with all regulatory requirements for safety, cleanliness, hygiene, and other issues as mandated by applicable governmental, licensure, and accreditation agencies.
 - e. Policy language that outlines the areas for review for physical plant safety. This includes, but is not limited to:
 - Medication areas are expected to be locked, secure, and clean.
 - Poison control number is posted in all clinical areas.
 - Medical reference material is readily available.
 - Emergency equipment accessibility to all staff.
 - Fire safety exits are labeled, freely accessed and well-lit, as well as fire safety maps posted in appropriate areas.
 - Smoking rules are posted.
 - All paints, solvents, flammable solutions, and sharps are monitored and used with supervision.
 - Staff can unlock bathroom doors, if necessary.
 - General use patient/consumer areas are available and have comfortable, safe furniture in good repair. Lighting is adequate for reading. All general use areas must be clean and orderly (e.g., no holes in walls, paint chips, graffiti, mold/mildew).
 - Calendars and clocks are visible in public areas; bulletin boards are used to communicate information.
 - The Bill of Rights, Grievance policy and the Fraud and Abuse Hotline Information is clearly posted in all clinical areas.
 - Biohazard containers are available in bathrooms.
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Progress/Session Notes policy: Providers shall have a policy regarding the protocol surrounding progress notes for ALL staff members who are authorized to document within the progress notes. (*Legal Reference:* 28 Pa Code §709.93(a)(5)).

- **0** = No policy exists or the existing policy lacks four (4) or more of the requisite elements.
- **1** = The policy exists, but lacks three (3) of the following elements:
 - a. Policy language that stipulates progress notes to be written following **all** individual, group, therapeutic/psychoeducational encounters, and case management activities within twenty four (24) hours of service/activity (*Legal Reference:* 28 Pa Code §709.93(a)(5); 28 Pa Code §709.84(9)).
 - b. Policy language that requires the documentation of the type of note, date and start/end time of encounter.
 - **Note:** The **time** of the encounter must be documented, e.g., “1:00pm – 2:00pm.”
 - c. Policy language that identifies the staff members authorized to write in the clinical record.
 - d. Policy language that discusses the Provider’s adopted format (e.g., DAP, SOAP, BIRP, PAIR, narrative) (*Legal Reference:* 28 Pa Code §709.93(5)(9)).
 - e. Policy language that defines the expected content of the adopted format.
 - f. Policy language that requires progress notes to be objective, include measurable criteria, and reflect treatment plan goals.
 - g. Policy language that requires documentation of interventions utilized/implemented during the therapeutic encounter, and response(s) to intervention(s).
 - h. Policy language that mandates the assessment of the consumer’s behavior, mood, and interpersonal functioning.
 - i. Policy language requiring that services (e.g., mobile therapy, art therapy) identified in the treatment plan are reflected in the progress notes.
 - j. Policy language that requires how the review of medical conditions and lab work will be included in the progress note.
 - k. *For group progress notes:* Policy language requiring the documentation of group topic and the individual consumer response to the group session (*Legal Reference:* 28 Pa Code §709.93(5)).
 - l. Policy language that requires all progress notes to be dated and to have a clinician’s original full signature with credentials (*Legal Reference:* 55 Pa Code §5200.41(b)(4)).
 - m. Policy language that mandates LEGIBILITY in the clinical record [*Legal References:* 55 Pa Code §1101.51(e)(1)(i); 55 Pa Code §5200.41(b)(1); 55 Pa Code §5221.33(4)(i)(a)]
 - n. Policy language that explains the appropriate procedure for correcting errors and/or making addendums to the chart.
 - o. Policy language requiring progress notes to reflect all treatment team members in the notes, and to show evidence of treatment continuity across disciplines.
- **2** = The policy exists and is not missing more than two (2) of the above elements.

Psychiatric/Psychological Evaluation policy: This policy should describe the indicators for the evaluation and the components of a psychiatric and/or psychological evaluation, and the baseline information that is to be collected.

- **0** = No policy exists, or the existing policy lacks **three (3) or more** of the requisite elements.
- **1** = A policy exists describing the process for the need of a psychiatric/psychological evaluation, and the baseline information which is to be collected, but lacks **two (2)** of the following elements:
 - a. Policy language that sets forth the **minimum** baseline information to be captured on an evaluation to be conducted and signed by a licensed professional.
 - Demographic information.
 - Presenting Problem.
 - Purpose of evaluation.
 - Mental Status exam.
 - Psychiatric/psychological tests utilized (*if applicable*).
 - Family composition/current living arrangements.
 - Community resource involvement (*if any*).
 - Consumer and family strengths and barriers to treatment.
 - Cultural factors.
 - Developmental history.
 - Interventions utilized to date.
 - Educational status.
 - Legal/DHS history.
 - Current medical status and comprehensive medical history (*Inpatient psychiatric services – Pa Code §1151.63(a)(2) & (3)*).
 - Mental and physical functional capability (*Inpatient psychiatric services – Pa Code §1151.63(a)(4)*).
 - Medication status (present and past history), including all known allergies.
 - Chronological psychiatric history.
 - Substance abuse history.
 - **Complete** DSM IV five (5) axes diagnosis.
 - Treatment recommendations (*Inpatient psychiatric services – Pa Code §1151.63(a)(6)*).
 - Prognosis [*Inpatient psychiatric services – Pa Code §1151.63(a)(5)*].
 - Discharge Planning.
- **2** = A policy exists, and is not missing **more than one (1)** of the above elements.

Quality Assurance policy: The provider will have a policy that discusses its commitment to quality service and the mechanisms that have been constructed within the agency to promote quality of care at all levels.

- **0** = No policy exists or the existing policy lacks two (2) or more of the requisite elements.
- **1** = The policy exists, but lacks one (1) of the following elements:
 - a. Policy language that discusses utilization review (*Legal Reference:* 55 Pa Code §1151.31(3); 55 PA Code §5200.44).
 - b. Policy language that discusses the protocol for a Continuous Quality Improvement Plan.
 - c. Policy language that discusses the protocol for a quality committee.
 - d. Policy language that discusses the policies and procedures for dealing with both external and internal quality monitors, and must list types of internal and external quality monitors.
 - e. Policy language that requires the development of an annual quality plan that addresses issues raised by the quality monitors.
- **2** = The policy exists and contains all of the requisite elements.

Referral System policy: The provider will have a policy that discusses its participation in a Behavioral Health System that offers a continuum of care to the consumer (*Legal Reference:* 55 Pa Code §157.42(a)(4)).

- **0** = No policy exists or the policy lacks three (3) or more of the requisite elements.
- **1** = A policy exists describing the mechanism for consumer referrals, but lacks **two (2)** of the following elements:
 - a. Policy language that discusses the procedure for incoming referrals.
 - **Note:** This can be incorporated within the discussion of Admission/Intake procedures.
 - b. Policy language that discusses the procedure for outgoing referrals.
 - c. Policy language that discusses the responsibility of the agency discharge information (e.g., discharge summaries, PCPC, ASAM) for all outgoing referrals.
 - d. Policy language that requires the agency to document the attempts to obtain discharge information (e.g., discharge summaries, PCPC, ASAM) from referring to forward agencies.
 - e. Policy language that requires referral agreements with other Behavioral Health System providers. **Note:** These agreements should be renewed every two (2) years.
 - f. Policy language that requires the collection/dissemination of specific information for both incoming and outgoing referrals amongst providers to be in compliance with the Department of Health and Public Welfare Bulletin (*Reference:* Vol. 99-00-05, November 28, 2000, – Consent Forms for the Release of Confidential Information).
- **2** = The policy exists and is not missing more than one (1) of the requisite elements.

Release of Information policy: Every provider shall have a policy and procedure on releasing consumer information that is separate and distinct from the policy on confidentiality. The policy should discuss when the release of information document becomes necessary, the contents of the document, and the procedures surrounding the attainment of consumer authorization for, and understanding of this document.

- **0** = No policy exists.
- **1** = A policy exists that discusses the procedure for releasing consumer information, but lacks **one (1)** of the following elements:
 - Policy language that discusses the content of the release of information. This should include:
 - **Note:** The content of a release of information document as outlined below is a comprehensive rendition of a thorough release of information. The required elements are compliant with Pennsylvania law for both mental health and substance abuse, **and** exceed the federal requirements of HIPAA (*Legal References:* 35 P.S. §7607(c); 28 Pa Code §701.1; 55 Pa. Code §5100.34).
 - Name of the consumer.
 - The name or title of the individual or organization permitted to disclose the requested information
 - Identification of the person, agency, organization to whom the disclosure will be made.
 - Statement identifying the specific information requested.
 - Statement of the specific purpose(s) for which the disclosure is to be used.
 - An established time limit on the validity of the consent that shows starting and ending dates, or the event or condition on which the consent will expire, if not earlier revoked.
 - A statement that the consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it. This revocation can either be oral or in writing.
 - A dated signature of the consumer or parent/guardian/legally-qualified representative, following a statement that the person understands the nature of the release.
 - Place for signature of staff member obtaining consent, and the date (or to record oral consent, with signatures of two (2) witnesses).
 - Written notice of prohibition of re-disclosure (*Legal Reference:* 28 Pa Code §709.28(c)(1-6)).
 - a. Policy language stipulating that a consumer may revoke a release of information at any time.
 - b. Language that discusses the procedure for explaining the purpose of the release of information to the consumer each time a release of information is utilized. Informing the consumer about the release of information includes discussing with the consumer on a 1:1 basis: the specific purpose for which the released records are to be used, the nature of the information that is to be released, the specific person/agency requesting the disclosure, the right the consumer has to revoke a release of information at any time, and the duration of the release of information.
 - c. Policy language that requires the consumer's signature on the release of information document indicating an understanding of all the above information contained within the release of information document.

- d. Policy language that states that the consumer consent to release information shall be offered to the consumer, and a copy maintained within the consumer record (*Legal Reference*: 28 Pa Code §709.28(d)).
- e. Policy language that requires any written or oral disclosures to be accompanied by a notice of prohibition of disclosure on all outgoing information.
 - **Note**: This Pennsylvania requirement exceeds the requirements established by HIPAA (*Legal Reference*: 55 Pa Code §5100.34(d)).
 - **Mental Health**: “The information has been disclosed to you from records whose confidentiality is protected by State and Federal statute. State regulations limit your right to make further disclosure of this information without prior written consent of the person to whom it pertains” (*Legal Reference*: 55 Pa Code §5100.34(d)).
 - **H.I.V.**: “This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of the HIV-related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.”
- f. Policy language stipulating that a release of information for CBH will be included within the clinical chart. **Note**: *Mental Health services only*.
- g. Policy language stipulating that any correspondence with an agency or individual about a consumer, attained through an authorized release of information shall be documented within the clinical chart.
 - **Note**: As per HIPAA, this element is necessary in case of future requests by consumers for an “accounting of disclosures.”
- h. Policy language that discusses the requirements for when a consent is not required (i.e., staff members shall fully document the disclosure in the consumer record; the consumer will be informed as soon as possible that the information was disclosed, for what purposes, and to whom (*Legal Reference*: 28 Pa Code §709.28(e)).

For Children’s Services only:

- i. Policy language that mandates that adults, or the parent/guardian of children under fourteen (14) years of age (as well as children who are fourteen (14) years of age and older) have the right to access patient records and have control over the release of such records (*Legal Reference*: 55 Pa Code §5100.33(a)(b)(c)(1)(2)).
- **2** = The policy exists and contains all of the requisite elements.

Restrictive Procedures policy (Adults): Any provider utilizing restrictive procedures as an intervention must have a clearly defined policy on the decision making process and the procedures for implementation. CBH expects that any provider using restrictive procedures will follow national standards and best practice guidelines. Providers should refer to the Mental Health and Substance Abuse Services Bulletin dated January 29, 1999. CBH is committed to supporting providers that offer care in a restraint-free milieu. Depending on the type of facility, restrictive procedures include chemical restraint, removal from the milieu, manual restraint, mechanical restraints, and seclusion. The following elements are not all-inclusive, and represent the minimum information required within the policy.

- **0** = No policy exists, or the existing policy lacks four (4) or more of the requisite elements.
- **1** = A policy exists regarding the procedure in the use of restrictive procedures, but lacks three (3) of the following elements:
 - a. Policy language indicating that restrictive procedures are used only when a consumer requires a safe environment and other less restrictive interventions have failed.
 - b. Policy language that identifies the provider's reasons for restrictive procedures, which can include:
 - Prevention of injury to the consumer.
 - Prevention of injury to others.
 - Prevention of major property damage.
 - c. Policy must have a statement that recognizes the provider's awareness that restrictive procedures deny the consumer's rights and must be used carefully and under specific guidelines.
 - d. Policy language that requires a physician's order for any restrictive procedures.
 - e. Policy language that indicates restrictive procedures may be instituted by a registered nurse in an emergency, but a physician's verbal order must be immediately obtained and the physician must personally assess the consumer within one (1) hour.
 - f. Policy language that requires orders for restrictive procedures to be rewritten every four (4) hours.
 - g. Policy language that requires a new physician's order to be obtained before a consumer may be returned to restrictive procedures after an early release.
 - h. Policy language that requires the use of restrictive procedures to be comprehensively documented within the clinical record, which includes at the minimum:
 - Interventions utilized before implementation of restrictive procedure.
 - Consumer's response to those interventions provided.
 - Evidence of consumer awareness of the specific behaviors that necessitated the use of restrictive procedures.
 - Evidence of consumer awareness of the behaviors that will terminate the restrictive procedures.
 - Evidence of observational documentation on a flow sheet at fifteen (15) minute intervals until restrictive procedures are discontinued.
 - Evidence of consumers being debriefed following release from restrictive procedures.
 - i. Policy language requiring the treatment plan to be updated after each restrictive procedure.
 - j. Policy language requiring progress notes to describe the following: symptoms requiring P.R.N. medication use, interventions strategies utilized pre-P.R.N., and consumer response to P.R.N. medications (*if applicable*).

- k. Policy language mandating that PRN medication orders for controlling acute episodic behavior are prohibited.
- l. Policy language that requires restrictive procedure training be conducted annually and that the training must be current within a year.
- m. Policy language that defines the contents of training to include:
 - The techniques approved for use, appropriate for age and weight of consumer.
 - Application of each restrictive procedure on the staff in training with return demonstration by all staff.
 - Assessment of health risks, if any, to the consumer.
- n. Policy language that prohibits the use of chemical restraints except under the following conditions:
 - Ordered by a licensed physician and administered by licensed/ certified/registered medical personnel on an emergency basis.
 - Immediately prior to each incidence of administering a medication in an emergency basis, a licensed physician shall have examined the consumer and given a written order to administer the medication. **Note:** Consumer’s vital signs shall be monitored at least once (1X) per hour, or as ordered by the physician. A designated staff member should document this information.

As to the Use of Seclusion: (Adult Inpatient Services only)

- a. Policy language that defines seclusion as “removal of a consumer from an immediate area and restriction of that consumer, alone, to a room or area.”
 - b. Policy language mandating that seclusion may not last longer than sixty (60) minutes within a two (2) hour period.
 - c. Policy language mandating that seclusion may not be used more than four (4) times in a twenty-four (24) period.
 - d. Policy language mandating that a staff member will observe the consumer at least every five (5) minutes while in seclusion and will record any observations on a flow sheet or log.
- **2** = The policy exists and is not missing more than two (2) of the above elements.

Restrictive Procedures policy (Children): This policy defines and describes the use of restrictive procedures. Depending on the type of facility, restrictive procedures include chemical restraint, exclusion (removal from the milieu), and manual restraint.

- **0** = No policy exists, or, the existing policy lacks four (4) or more of the requisite elements.
- **1** = A policy exists that defines and describes the use of restrictive procedures, but lacks three (3) of the following elements:
 - a. Policy language that states that upon admission, the provider informs both the consumer and/or parent/legal guardian/custodian of its policy regarding the use of manual or chemical restraint or exclusions during an emergency safety situation in a language understood by the parties notified. The facility must obtain, in writing from the resident and/or parent/legal guardian/custodian, that he/she has been informed and understands this policy. A copy of that policy must be provided to the recipient and the parent/legal guardian/custodian. Information on how to contact the State Protection and Advocacy Organization (1-800-692-7443) shall be included in the written material (**Legal Reference:** Medical Assistance Bulletin #53-01-01, dated July 20, 2001; *see also*, 42 CFR §483.356 (c)).

- b. Policy language that states that all residents of Residential Treatment Facilities (RTF) have the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. **Note:** JCAHO-accredited RTF services only. (*Legal Reference:* Medical Assistance Bulletin #53-01-01, dated July 20, 2001; *see also*, 42 CFR §483.356; 55 Pa Code §§3800.32(b)(n)).
- c. Policy language that requires a provider to report a resident’s death, any serious injury to a resident, or a resident’s suicide attempt to the Office of Children, Youth and Family Services Regional Office in accord with existing 55 Pa Code §3800 requirements, and to the Pennsylvania Protection and Advocacy Organization, and to Medicaid no longer than twenty-four (24) hours after the serious occurrence. **Note:** JCAHO-accredited RTF services only (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also*, 42 CFR §483.374(b)).
- d. Policy language that requires RTF facilities to adhere to the federal requirements under 42 CFR 483 Subpart G, “Conditions of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21,” for those restrictive procedures permitted by State and Federal law. **Note:** JCAHO-accredited RTF services only. (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
- e. Policy language that states that “the only restrictive procedures ever permitted by participating Medical Assistance (MA) RTF providers are manual restraint(s), chemical restraints, and exclusion. **Note:** JCAHO-accredited RTF services only. (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
- f. Policy language that prohibits the use of mechanical restraints and seclusion. **Note:** JCAHO-accredited RTF services only. (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
- g. Policy language that requires for each incident in which the use of restrictive procedures is considered, every attempt shall be made to anticipate and de-escalate the behavior using a methodology/intervention less intrusive than restrictive procedures. **Note:** JCAHO-accredited RTF services only. (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
- h. Policy language that describes, in detail, the de-escalation and intervention techniques used to avoid the necessity for restrictive procedures.
- i. Policy language that defines an emergency safety situation as an unanticipated resident’s behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also*, 42 CFR §483.352; 55 Pa Code §3800.202(b)).
- j. Policy language that clearly defines manual restraint, chemical restraint, and exclusion as defined in 42 CFR §483.352 and 55 Pa Code §3800 (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
- k. Policy language that requires staff to contact the family/guardian/custodian as soon as possible after the initiation of any emergency safety intervention. If the child is in the custody of a Child and Youth Agency, the custodial County Children and Youth Agency is notified. **Note:** JCAHO-accredited RTF services only (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also* 42 CFR §483.366).

As to the Training of Staff:

- a. Policy language that states that staff may not be involved in the application of restrictive procedure unless they have completed training within the past year in the use of that procedure. Federal regulations further require that staff must demonstrate competency before participating in an emergency safety intervention (***Legal Reference:*** Medical Assistance Bulletin #53-01-01, dated July 20, 2001; *see also*, 42 CFR §483.376; 55 Pa Code §3800.205).
- b. Policy language that requires providers to provide ongoing education and training for staff in restrictive procedures and de-escalation techniques. Staff must demonstrate their competencies of emergency safety interventions on a semi-annual basis. CPR certification must be reviewed annually. (***Legal Reference:*** Medical Assistance Bulletin #53-01-01, dated July 20, 2001; *see also*, 42 CFR §483.376(g); 55 Pa Code §3800.58(h)).
- c. Policy language that discusses the provider's duty to record training completion and demonstration of competency in the employee's personnel record. All training programs and materials used by the facility must be available for review by the Center for Medicare and Medicaid Services (ex- HCFA), the State Medicaid agency, and the State survey agency. (***Legal Reference:*** Medical Assistance Bulletin #53-01-01, dated July 20, 2001; *see also*, 42 CFR §483.376(g); 55 Pa Code §3800.58(h)).
- d. Policy language that states that each party involved in restrictive procedures may only perform as permitted by their training and scope of practice.

As to the Use of Restrictive Procedures:

- a. Policy language that states that there may not be standing orders for restrictive procedures. As necessary, the order is obtained, and the order is to be the least restrictive intervention that is likely to be effective, specific, and time-limited to the duration of the emergency safety situation only.
- b. Policy language that requires a provider to report any restraint-related death to the Center for Medicare and Medicaid Services (ex- HCFA) Regional Office no later than close of the next business day after the resident's death. **Note:** JCAHO-accredited RTF services only (***Legal Reference:*** Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also*, 42 CFR §483.374(c)).
- c. Policy language stating that any order for restrictive procedures is limited to four (4) hours for consumers age eighteen (18) to twenty-one (21), two (2) hours for children and adolescents, ages nine (9) to seventeen (17) years, and one (1) hour for children under the age of nine (9). (***Legal Reference:*** 42 CFR §483.358).
- d. Policy language on manual restraints which states the following:
 - Physicians, certified nurse practitioner (CRNP), physician assistant (PA), licensed psychologist, registered nurses (RN), and licensed social worker (LSW) or licensed clinical social worker (LCSW) may order the use of manual restraints, in that order. **Note:** JCAHO-accredited RTF services only (***Legal Reference:*** Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
 - The resident's treatment team physician must be contacted and informed about the use of restraint, unless the ordering licensed professional is also the resident's treatment team physician. **Note:** JCAHO-accredited RTF services only. (***Legal Reference:*** Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
 - Prohibition against any hold that applies pressure or weight to the youth's respiratory system.
 - Prone position manual holds for pregnant girls are prohibited.
 - Manual holds must be changed every ten (10) consecutive minutes of the hold.

- Policy language requiring staff members not involved in applying the hold to observe and record the physical and emotional condition of the youth at least every ten (10) minutes the hold is applied.
 - Policy language mandating that manual holds may not be maintained longer than thirty (30) minutes during any one event.
 - Manual restraints must be discontinued when the consumer demonstrates they have gained self-control. **Note:** JCAHO-accredited RTF services only (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also*, 55 Pa Code §3800.202(c)(3)).
 - Should the emergency situation extend beyond the time of the order, licensed staff must contact the ordering licensed practitioner for guidance. **Note:** JCAHO-accredited RTF services only (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
- e. Policy language that requires a face-to-face assessment of the physical and psychological well-being of the consumer must be conducted within one (1) hour of the emergency safety intervention and when the restraint is removed. This may be performed by a physician, certified registered nurse practitioner (CRNP), physician's assistant (PA) or registered nurse (RN). **Note:** JCAHO-accredited RTF services only. *Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001.
- f. Policy language that requires within twenty-four (24) hours after a resident has been restrained, staff involved in the emergency safety intervention and the consumer shall participate in a face-to-face discussion. Other staff, family, guardian(s), or custodian may participate when deemed appropriate by the facility. **Note:** JCAHO-accredited RTF services only (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also* 42 CFR §§483.360 and 370(a)).
- g. Policy language that requires a staff debriefing within twenty-four (24) hours after resident has been restrained. A review of the situation that required the restraint by all staff involved in the incident shall occur. Appropriate treatment team members and supervisory and administrative staff shall attend in order to identify areas requiring modification to administrative policy and procedures and, if injuries were present, to prevent future injuries. Documentation of the above meetings shall be recorded in the consumer's record. **Note:** JCAHO-accredited RTF services only. (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also*, 42 CFR §483.370(b) & (c)).

As to the Documentation Standards:

- a. Policy language that requires the development of a plan for the use of restrictive procedures, and that requires it be included in the Individual Service Plan for those consumers whose treatment includes those interventions.
- b. Policy language that identifies the minimum information to be documented within the plan regarding the use of restrictive procedures to include:
- Specific behaviors to be addressed.
 - Desired measurable outcomes.
 - Specific interventions and restrictive techniques.
 - Staff authorized to apply the technique or procedure.
- c. Policy language requiring the plan to be reviewed every treatment period and revised as necessary.
- d. Policy language that requires evidence that the plan has been reviewed and revised with the participation of the child, the parent/legal guardian/custodian (*whichever applies*).
- e. Policy language requiring a copy of the plan to be kept in the clinical record.
- f. Policy language that identifies the minimum information to be collected/ documented on any restrictive procedure to include:

- Specific behavior addressed/interrupted.
 - Interventions attempted before the restrictive procedures and the consumer's response.
 - Specific restrictive procedure used, along with the date, time, and duration of procedure.
 - Name of staff person applying procedure and the name of the staff observer.
 - Condition of the consumer following termination of the restrictive procedure.
 - Who has been notified of the emergency safety intervention, including the date, time of the notification, and the name of the staff member providing the notification. **Note:** JCAHO-accredited RTF services only. (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also*, 42 CFR §483.366).
 - **For Manual restraints:** in the case of a verbal order, the ordering practitioner must countersign the verbal order.
- g. Policy language that prohibits the use of pressure point techniques, except for the purpose of bite release.
- h. Policy language that prohibits the use of mechanical restraints. **Note:** JCAHO-accredited RTF services only (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001).
- i. Policy language that prohibits the use of chemical restraints except under the following conditions:
- Ordered by a licensed physician and administered by licensed/certified/ registered medical personnel on an emergency basis.
 - Immediately prior to each incidence of administering a medication in an emergency basis, a licensed physician shall have examined the consumer and given a written order to administer the medication. **Note:** Consumer's vital signs shall be monitored at least once (1X) per hour, or as ordered by the physician. A designated staff member should document this information.
- j. Policy language that states that in the event of chemical restraint, a physician must complete a written order for the administration of the drug based upon the physician's examination of the individual before the order is written. **Note:** JCAHO-accredited RTF services only (*Legal Reference:* Medical Assistance Bulletin #53-01-01 dated July 20, 2001; *see also* 55 Pa Code §3800.209).
- k. Policy language mandating that PRN medication orders for controlling acute episodic behavior are prohibited.
- **2** = The policy exists and is not missing more than two (2) of the above elements.

Suicide Assessment policy: The Provider shall have a policy that reflects staff responsibility in recognizing suicidal feelings and observing suicidal behavior. The policy shall include provisions for safety, reportability of signs and symptoms of suicidality, and treatment.

- **0** = No policy exists or the policy lacks three (3) or more of the requisite elements.
- **1** = The policy exists reflecting the staff responsibility in recognizing suicidal feelings and observing suicidal behavior, but lacks two (2) of the following elements:
 - a. Policy language that requires progress notes to reflect the events precipitating the need for a suicide assessment.
 - b. Policy language that requires the progress notes to contain the consumer's behavior, mood/affect, and level of observation.
 - c. Policy language that requires the documentation of the time and date physician was notified of the need for assessment.
 - d. Policy language requiring documentation of the time and date assessment was completed.
 - e. Policy language that requires the assessment to contain a clinical summary and determination of consumer's level of care.
 - f. Policy language shall include the process of implementing the appropriate level of care as a result of the assessment.

Inpatient only:

- g. Policy language that requires the documentation by the physician, if suicide precautions have been ordered, including date, time, and level of observation.
 - h. Policy language that requires the treatment plan to reflect the interventions to be utilized and identification of the person(s) responsible for implementing them.
 - i. Policy language that requires the flow sheet to contain the level of precaution, date, time, location, activity, and legible signature.
 - j. Policy language that requires the nurse to record, on each shift, a progress note indicating the level of care, behavior, mood, response to consumer precautions, and compliance with contract.
 - k. Policy language that requires the documentation of the process for discontinuation of suicide precautions, including physician order.
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Treatment Plans policy (Initial and Updated): All providers must develop a policy and procedure on the development and construction of treatment plans (*Legal Reference:* 28 Pa Code §709.92).

- **0** = No policy exists or the policy lacks three (3) or more of the requisite elements.
- **1** = The policy exists, but lacks two (2) of the following elements:
 - a. Policy language that discusses the purpose of the initial/updated treatment plan.
 - **Example:** “The treatment plan serves as an organizational tool whereby the care rendered each consumer is designed, implemented, assessed, and updated in an orderly and clinically sound manner.”
 - **Example:** “To develop a concise, objective and measurable clinical reference point to determine the degree (or lack thereof) of responsiveness a consumer is demonstrating with respect to his or her treatment at the Provider’s agency.”
 - b. Policy language that requires the treatment plan to reflect input from **all** disciplines and the consumer (interdisciplinary treatment plan development).
 - c. Policy language that requires consumer privacy and confidentiality to be maintained throughout the treatment plan process.
 - d. Policy language that discusses the specific timelines that are applicable to completing the treatment plan/service plan updates. The timeframes listed below are the state minimums; CBH reserves the right to require more frequent treatment planning.
 - Outpatient Mental Health Treatment: every 15 sessions or 120 days, whichever occurs first (55 Pa Code §1153.52(a)(7)(ii)).
 - Outpatient Drug and Alcohol Treatment: Initial within thirty (30) days and updates every sixty (60) days (55 Pa Code §157.42(c)).
 - Partial Hospitalization Mental Health Treatment programs: every thirty (30) days.
 - Inpatient Mental Health Treatment programs: every seven (7) days.
 - Inpatient Hospital Drug and Alcohol Treatment: every 15 days (55 Pa Code §157.42(c)).
 - Targeted Case Management: Service Coordination Plan updated every 30 days (55 Pa Code §1247.42(b)(3)(v)).
 - e. Policy language that requires treatment plans to document the admission date, the date of the initial treatment plan, the date of the present treatment plan, and the date of the subsequent treatment plan.
 - f. Policy language that requires documentation of the expected duration of the treatment.
 - g. Policy language that requires treatment plans to reflect behaviorally defined problem statements.
 - h. Policy language that requires treatment plan goals to be realistic, objective, stated in measurable terms, and behaviorally based (*Legal Reference:* 28 Pa Code §709.92(a)(1)).
 - i. Policy language that requires treatment plans to be strength-based and will identify the strengths/barriers of the consumer on all treatment plans.
 - j. Policy language that requires treatment plans to reflect the five (5) axes diagnosis.
 - k. Policy language that requires treatment plans to reflect the methods of treatment (*Legal Reference:* 28 Pa Code §709.92(a)(2)).
 - l. Policy language that requires treatment plans to reflect interventions and action steps.
 - m. Policy language that requires treatment plans to reflect initial discharge planning.
 - n. Policy language that identifies how the consumer is involved in the treatment planning process (*Legal Reference:* 55 Pa Code §5200.31(5)).
 - o. Policy language requiring the identification of persons responsible for the implementation of interventions (*Legal Reference:* 55 Pa Code §1223.42(b)(1)).

- p. Policy language that explains the mechanism to change, add, and delete goals.
 - **Example:** “It should be noted that a consumer’s treatment plan may be changed by the person’s primary therapist/counselor at any time should the goals and objectives be deemed inappropriate and/or unnecessary for any clinical reason.”
 - q. Policy language that discusses the requirement to document progress towards (or lack thereof) goal attainment in updated plans (*Legal Reference:* 28 Pa Code §709.92(b)).
 - r. Policy language stating that lack of improvement will be subject to careful analysis by the treatment team.
 - s. Policy language that requires active participation and signature of the primary caregiver (legal guardian, parent) and/or the consumer for the development of, **and** any changes to, the treatment plan.
 - t. Policy language requiring a statement of understanding on treatment plans (initial and updated) be signed by the consumer (*if capable*).
 - u. Policy language that requires treatment plans to be LEGIBLE.
 - v. *For children’s services only:* Policy language that discusses how the educational needs of the consumer are provided when treatment causes an absence from school.
- **2** = The policy exists and is not missing more than one (1) of the above elements.

Determining the Policy Score

The points for all of the policies are totaled and the following formula is utilized to determine the policy score:

$$\frac{\text{Total Points Received}}{\text{Total Possible Points}}$$

Example: If all policies were applicable, the Agency can attain 60 total points (100%). If the Agency received 52 points, then:

1. $52/60 = .866$
2. $.866 = 87\%$
3. Policy score (87%) = Category 3

<u>Total Score</u>	<u>Category</u>
81% and above	3
61% - 80%	2
60% or below	1

Policy Exemption Requests

Requests for exemption from any forms and/or policies required by CBH and found within this manual shall be made in writing. A request must be submitted prior to the date of the site visit. It is recommended that policy exemption requests should not be submitted without discussion around the issues. All discussions should be directed to the Manager for Credentialing and Quality Review.

Clinical Review Requirements

Introduction

The Clinical Audit form was created by the Provider Network Operations Department to define the clinical documentation areas of review for agencies that provide treatment to BHS consumers. The form describes the documentation review elements so that all providers are fully informed regarding clinical expectations. The Clinical Audit tool was designed by a CBH team of multidisciplinary professionals and reflects an integration of best practice industry standards, accreditation standards, and State regulatory and monitoring guidelines.

The scope of the clinical audit will include the following categories in all reviewed clinical records:

- Intake Documentation.
- Assessment.
- Comprehensive Biopsychosocial Evaluation.
- Comprehensive Biopsychosocial Re-Evaluation.
- Treatment Planning.
- Progress Notes.
- Medication Management.
- Discharge Documentation.

The following categories will be reviewed when the documentation in the record indicates that the categories are appropriate areas for review:

- Seclusion/Restraint.
- Suicide Intervention.
- AMA/AFA discharges.

Each category is comprised of specific elements related to the area being reviewed, and all elements within all categories are equally weighted.

Scoring

A protocol has been developed to standardize the scoring among the auditors who are trained to use this protocol in order to maintain high inter-rater reliability. The quality and content of the clinical charts within the behavioral health system are ranked on a 0, 1, 2 point system. Each element within each category will be scored on this scale. The Clinical Audit tool scoring process is completed in five steps and is outlined below. Using industry standards as a guide, a random sample of ten percent (10%) of the clinical files will be reviewed during an official clinical audit. However, CBH retains the privilege of reviewing all clinical charts, when deemed necessary. **Important Note:** SEE, Pa Code §1101.51(1)(i). The record shall be legible throughout.

0 = The clinical chart does not possess the requisite category elements at all or is illegible.

1 = The clinical chart contains the category element, but the requisite element is not comprehensive and/or complete.

2 = The clinical chart contains the required category element, and is complete.

1. Scores are compiled across all elements in a category for each reviewed record.
2. Each element score is then added and divided (actual scores/possible scores) yielding a raw ratio and/or percentage.
3. These element raw scores are then compiled to provide a ratio and/or percentage for each category.
4. Finally, each category ratio is added to provide an overall clinical score. This overall score can be expressed as a ratio or percentage.

Intake Documentation

Each clinical chart will contain the following intake documentation:

- The presence of a standardized format/order/chronology of standard consumer information forms.
- Completed and updated concurrent reviews.
- A completed and signed current PCPC summary sheet (*Substance Abuse services only*).
- A completed intake sheet containing consumer's demographic information. The following list represents the minimum information that will be collected:
 - Name.
 - Address.
 - Telephone number.
 - Emergency contact.
 - Marital Status (*if applicable*).
 - Gender.
 - Ethnicity.
 - Religion.
 - Date of Birth.
 - Primary Language.
 - Social Security Number.
 - Primary Care Physician.
 - Insurance information.
 - Date and time of interview.
 - Staff signature.
- Current consumer rights form with statement of understanding within its contents, signed and dated by the consumer (parent/legal guardian/custodian) and the provider representatives, **or**, clear documentation that consumer has received an agency handbook that includes the consumer rights.
- Consent for treatment for current level of care with signed statement of understanding.
- Signed and dated release of information, specific to CBH (*Mental Health services only*).
- Documentation of (or attempts to obtain) a physical exam, a medical questionnaire, or immunization record.

Assessment & Evaluation

Each assessment must be LEGIBLE and will contain, at the minimum, the following information:

- Behaviorally defined presenting problem(s).
- Comprehensive medical history.
- Consumer allergies identified (drug, food and environmental).
- Comprehensive psychiatric history.
- Comprehensive substance abuse history.
- Comprehensive history of **past** medications.
- Comprehensive documentation of **current** medication history, including, name of drug, dosage, frequency, prescribing physician and purpose.
- Comprehensive educational history.
- Comprehensive maturational history (*Children and M.R. consumers only*).
- Comprehensive spiritual history.
- Comprehensive nutritional history.
- Comprehensive vocational/occupational history.
- Comprehensive legal history.
- Comprehensive sexual history.
- Past/Present history of aggression/suicidality/abuse, when identified.
- Comprehensive list of social elements of a consumer's life.
- Detailed summary of consumer's support system.
- DSM IV five (5) axes diagnosis.
- Consumer's initial goals for treatment. Goals must be realistic, individualized and appropriate.
- Consumer strengths and barriers to treatment.
- A mental status exam.
- Evidence of initial discharge planning.
- Documentation that provides evidence that the assessment was completed within time frame indicated by Agency policy.

Comprehensive Biopsychosocial Evaluation (CBE)

The CBE will entail direct interviews with the consumer family/guardian, DHS/JJS, adult legal system, and other treatment providers. The CBE will also entail observation of the interaction between consumer and family, as needed, and the child in the school or applicable community setting if behavioral health services are being recommended to be provided there. If the child or adolescent is involved in the juvenile justice or child welfare systems, it is important to obtain records and current information. Records from relevant prior pediatric, psychiatric, psychological, or special education evaluations should be reviewed. The following represents the information required for all comprehensive biopsychosocial psychological and psychiatric evaluations for children, adolescents, and adults. The purpose of the CBE is to evaluate clinically an individual's need for behavioral healthcare and to determine what type of care is needed. Licensed psychologists, licensed psychiatrists and masters prepared mental health professionals will be eligible to participate in the evaluation process. Each assessment must be LEGIBLE and will contain, at the minimum, the following information as defined by the CBH Bulletin dated, February 28, 2003:

- Evidence that a licensed psychologist/psychiatrist completing at least two (2) units of the evaluation (*mental health services only*).
- Behaviorally-defined chief complaint(s)/presenting problem(s).
- Comprehensive history of present illness.
- Comprehensive developmental history.
- Comprehensive behavioral health treatment history.
- Comprehensive medical history, including allergies and **family** medical history.
- Comprehensive social history.
- Comprehensive occupational and/or educational history.
- Comprehensive assessment of consumer and family behaviors.
- Comprehensive substance use/abuse history and assessment.
- DSM-IV five (5) axes diagnosis.
- A Mental Status Exam.
- Reflection of an integration of received collateral information from outside agencies within the evaluation process, if applicable.
- Reflection of an integration of received laboratory tests/medical reports within the evaluation process, if applicable.
- Reflection of an integration of data received from structured tools (i.e., diagnostic instruments) within the evaluation process, if applicable.
- Comprehensive biopsychosocial formulation based on the collected information.
- Comprehensive problem list with recommendations for interventions.
- Evidence that each evaluation contains an accompanying document to the evaluation that specifically indicates the date and clock hours of the time spent on the evaluation by each evaluation participant and the corresponding LEGIBLE signature.

Comprehensive Biopsychosocial Re-Evaluation (CBR)

The purpose of the CBR is to re-evaluate clinically an individual's need for continued behavioral healthcare and to determine what type of further care may be needed. Licensed psychologists, licensed psychiatrists and masters prepared mental health professionals, will be eligible to participate in the evaluation process. Each assessment must be LEGIBLE and will contain, at the minimum, the following information as defined by the CBH Bulletin (#03-08) dated, April 25, 2003:

- Statement of clinical justification indicated the need for re-evaluation.
- Demographic information (i.e., address, phone, SS#, DOB).
- Reflection of medical issues (*when presented*).
- Treatment plan review (progress/lack thereof).
- Assessment of substance use/abuse (*when clinically indicated*).
- DSM-IV five (5) axes diagnosis.
- A Mental Status Exam.
- Reflection of an integration of received collateral information from outside agencies within the evaluation process, if applicable.
- Reflection of an integration of received laboratory tests/medical reports within the evaluation process, if applicable.
- Reflection of an integration of data received from structured tools (i.e., diagnostic instruments) within the evaluation process, if applicable.
- Updated clinical formulation based on the collected information.
- Comprehensive problem list with recommendations for interventions.
- Evidence that each evaluation contains an accompanying document to the evaluation that specifically indicates the date and clock hours of the time spent on the evaluation by each evaluation participant and the corresponding LEGIBLE signature.

Treatment Plans

Each clinical chart will contain a LEGIBLE treatment plan, and when applicable, an updated treatment plan. The treatment plans will contain the following elements:

- Date of admission, date of initial treatment, date of subsequent treatment plan, and date of present plan.
- DSM-IV five (5) axes diagnosis.
- Behaviorally defined problem statement(s).
- Measurable treatment goals. Both long and short-term goals are appropriate and are presented in behaviorally measurable terms (*Legal Reference: 55 Pa Code §157.42(b)(1)*).
- Evidence of an interdisciplinary team approach (i.e., psychiatry, nursing, social service, group, and individual therapies) (*Legal Reference: 55 Pa Code §5100.15(4)*).
- Proof of consumer involvement in formulation of goals. Consumer's signature appears on treatment plan, and evidence of participation, acceptance and statement of understanding of plan is present.
- Methods of treatment (e.g., individual and/or group therapy, components of EPSDT, case management) along with designated frequencies and duration are documented (*Legal Reference: 55 Pa Code §157.42(b)(2)*).
- Interventions are specified (*Legal References: 55 Pa Code §157.42(b)(3); 55 Pa Code §1223.42(b)(1); 55 Pa Code §1153.42(b)(1)(ii)*).
- Staff responsibility for interventions is documented (*Must be discipline specific*). (*Legal Reference: 55 Pa Code §1223.42(b)(1); 55 Pa Code §1153.42(b)(1)(iii)*).
- Consumer's strengths and barriers to treatment are noted.
- All treatment team members (including consumer) sign treatment plans.
- All treatment plan updates will include a statement of progress towards (or lack thereof) all current goals. Will present progress towards goals from the time of the previous treatment plan.
- Treatment plans are legible, including signature and dates.
- Initial treatment plans and/or updated treatment plans are completed within the applicable time frame.
- ***For children's services only:*** Educational plan reflected.
- A nursing care plan that identifies physical problems (*where applicable*).
- Appropriate nursing and medical interventions (*where applicable*).

Progress/Session Notes

Each chart will have progress/session/chart notes, containing the following elements:

- Time and date of entry (e.g., “3:00pm – 4:00pm”).
- Type of service is denoted (e.g., individual, group, family).
- Assessment of consumer behavior, mood, and interactions with others.
- Documentation of staff intervention(s) and the consumer’s response(s) to those staff interventions.
- Progress notes should contain a depiction of progress towards (or lack thereof) established treatment plan goals, and any other pertinent clinical information.
- When applicable, reference medical conditions and/or lab work.
- Follows a format (e.g., SOAP, DAP, BIRP, PAIR) as indicated by agency policy. **Note:** The quality of the content of the agency format utilized will also be reviewed.
- Documentation of a plan for continued treatment. **Note:** A plan is NOT merely the date and time of the next appointment.
- Progress notes contain documented evidence of follow-up on plan established at last session.
- An original and legible signature of the clinician along with job title and their credentials. **Note:** This also applies to group notes.
- Evidence of the integration of the treatment team.
- The notes are LEGIBLE.

As to the content of Group Notes:

- Group note contains the topic of the group session.
- Group note contains an individualized consumer response to the session.
- Group note contains an original and legible signature.
- Group note contains comprehensive documented evidence of the nature and extent of the group session(s) as related to the treatment plan.

Psychiatric/Psychological Evaluation

Each psychiatric/psychological evaluation **must be** LEGIBLE and will contain, **at the minimum**, the following information:

- Demographic information.
- Presenting problem(s).
- The purpose of evaluation.
- Mental Status exam.
- Psychiatric/Psychological tests utilized (*if applicable*).
- Family composition/current living arrangements.
- Community resource involvement (*if any*).
- Consumer and family strengths and barriers to treatment.
- Cultural factors.
- Developmental history (*M.R. consumers and children only*)
- Interventions utilized to date.
- Educational status.
- Legal/DHS history.
- Current medical status and comprehensive medical history.
- Medication status (present and past history), including all known allergies.
- Mental and physical functional capability (*inpatient psychiatric services*).
- Comprehensive and chronological psychiatric history.
- Comprehensive substance abuse history.
- **Complete** DSM IV five (5) axes diagnosis.
- Treatment recommendations.
- Discharge Planning.

Discharge Documentation

Each chart that contains discharge documentation will document the following elements:

Discharge Note

- Consumer's behavior and attitude upon discharge.
- Consumer's destination and mode of transportation (*inpatient only*) upon discharge.
- Treatment outcomes.
- Evidence that consumer has been informed of and is aware of any aftercare recommendations.

Aftercare Planning

- All the critical problems of the consumer.
- Aftercare plans contain the signature of the consumer.
- Aftercare plans reflect the follow-up appointments that have been made for the consumer upon discharge.
- Aftercare plans identify appropriate living arrangements for the consumer (*inpatient only*.)
- Aftercare plans reflect the consumer's method for obtaining medications (*if applicable*) subsequent to discharge.
- Aftercare plans reflect a crisis plan for the consumer.

Discharge Summary

- Reasons for treatment.
- Services offered.
- Initial and Final five (5)-axes diagnosis.
- Summary of consumer's progress or lack thereof.
- Medication information (*if applicable*).
- Recommendations for aftercare.
- Special Needs of the Consumer.
- Consumer status or condition upon discharge.
- Medical/Psychosocial problems of consumer are noted.
- Anticipated problems/concerns for future compliance.
- Signature of psychiatrist and/or clinical director is present.

Transfer Summary (Inpatient services only)

- Evidence of a physician order being completed for the transfer.
- Condition of consumer upon transfer.
- Evidence that consumer was informed of reasons for transfer.
- Consumer response to transfer.
- Transfer medications documented.
- Evidence that the family/support network of the consumer was notified of the transfer (*consumers <14 only*).
- Comprehensive transfer note, including date, time, method of transfer and medications provided within the past four (4) hours (*if applicable*).
- Signature of psychiatrist and/or clinical director is present.

Medication Management

Each clinical chart that requires the presence of medication documentation will contain the following elements:

Medication Log/Orders

- Consumer's name.
- Date of the order.
- Name(s) of medication(s).
- Dosage of medication.
- Route of administration.
- Schedule of medication.
- LEGIBLE physician's signature. (For every entry date).
- Evidence of informed consent for medications by the consumer as discussed in the "Informed Consent" policy (pg. 39-40) above.
- Comprehensive documented reasons for increases, decreases, and/or discontinuations of medications.
- Medication Kardex is maintained according to hospital policy (**Note:** Inpatient and RTF services only). All elements identified in the hospital policy will be present and recorded as required.
- ALL information is LEGIBLE.

P.R.N. Medications

The documentation of P.R.N. medications will include evidence of the following elements:

- A physician order, which possesses ALL of the following:
 - a. Name of medication.
 - b. Dosage of medication.
 - c. Route of Administration.
 - d. Frequency of medication.
 - e. Reason medication is given.
 - f. Legible physician's signature (**Note:** if verbal order, it will be signed as required by hospital policy).
- Intervention strategies utilized prior to P.R.N. medication administration
- Progress notes describing symptoms that justify the reason for the P.R.N. medication.
- Consumer's behavior is described in the progress note, including response(s) to the P.R.N. medication.
- P.R.N. medication is recorded on kardex (*where applicable*). Must be in compliance with documentation requirements per agency policy, along with R.N./Graduate Nurse's initials and/or signature.
- The documentation of the maintenance of P.R.N. medications is LEGIBLE.

Suicide Precautions

If suicidal precautions become necessary, each clinical chart will document the following elements:

- Assessment of consumer by physician, and presence of corresponding order/note (*inpatient services only*).
- Reasons for suicide precautions are documented (e.g., behaviors, verbalizations, threats).
- Time physician was called for precaution orders (inpatient only).
- Consumer's response to precautions (e.g., verbalizations, behaviors).
- Flow sheet indicating the precaution level, restriction, consumer location and behavior (inpatient only).
- Evidence of an attempt to contract for safety (verbal or written).
- Evidence of an amended treatment plan reflecting change in consumer status.
- A comprehensive description of:
 - a. Consumer behavior (pre- and post- precaution).
 - b. Mood/affect (pre- and post- precaution).
 - c. Compliance with contract for safety.
- Physician order to discontinue suicidal precautions (inpatient only).
- All documentation is LEGIBLE.

Restrictive Procedures

Each clinical chart that contains evidence of the need for the use of restrictive procedures will document the following elements:

- Documentation of the incident itself prior to use of interventions.
- Evidence of psychosocial interventions or medication interventions used prior to restrictive procedures:
- Evidence that options for behaviors were suggested to the consumer.
- Evidence that consumer redirection attempts were made.
- Evidence that a behavioral contract (verbal or written) was developed.
- Evidence that medication orders were followed, if applicable.
- Evidence that P.R.N. medications were ordered, if applicable.
- Evidence that response to P.R.N. medications were noted by RN, if administered.
- Evidence that physician was notified of escalating behavior.
- Evidence that physician ordered restraints/seclusion at time escalating behavior was identified.
- Evidence that the decision for seclusion/restraint was consistent with criteria described by hospital policy.
- Evidence that all interventions were appropriate.

When restrictive procedures become necessary, each clinical chart will document the following elements:

- Psychosocial interventions attempted before seclusion or restraint, and the outcomes of those attempts.
- Written justification for seclusion/restraints is prepared by the nurse and includes:
 - a. Behavior during procedure.
 - b. Response to event.
 - c. Criteria for removal.
- Evidence that a revision in the treatment plan was made reflecting consumer's change of status.
- Written justification for removal of seclusion/restraints is prepared by a nurse, and includes:
 - a. Assessment of behavior required for removal of seclusion/restraints is appropriate.
 - b. Description of interventions used while consumer was in seclusion/restraints.
 - c. Consumer criteria for removal of restrictive procedures and behaviors necessary for the removal of restrictive procedures are explained to the consumer.
- A plan post-restrictive procedures. **Note:** Includes 1:1, eyesight supervision, processing of events leading to event, formulation of interventions to be used in future if similar triggers of consumer's behavior are present.
- Review/signature of nurse, providing evidence that restrictive procedures were reviewed by a nurse.

Against Facility Advice (AFA)/ Against Medical Advice (AMA)/ Administrative Discharge

Each clinical chart that contains an AFA/AMA/Administrative discharge will document the following elements:

- The AFA/AMA form is signed by the consumer and if not, the reason for lack of signature.
- Treating clinician has completed the staff portion of the form.
- AFA/AMA decision is discussed with the consumer and noted in chart.
- Documentation of:
 - a. Reason for the AFA/AMA.
 - b. Time and name of physician notified.
 - c. Actions taken by staff.
 - d. Consumer response to intervention(s).
 - e. Aftercare attempts.
 - f. CBH notification of AFA/AMA.

Appendices

Appendix A: Confidentiality policy

To assure the confidentiality of consumer information, CBH has established this policy and, together with the distribution of appropriate procedures implementing the policy, will provide instruction and training to all employees regarding the importance of maintaining confidentiality to the greatest extent possible. At present, the language and content of the confidentiality and release of information policies are compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 and the more stringent Pennsylvania laws.

This policy applies to all consumers and to all consumer records. All staff members must strictly adhere to the confidentiality policies as set forth herein. All employees of a facility must be informed of the rules and regulations regarding confidentiality of records and also be informed that violation of those rules could potentially subject them to civil or criminal liability (*Legal Reference: 55 Pa Code §5100.35(d)*). Providers are required to protect the confidentiality of all information in its records from unauthorized disclosure at all stages of collection, use, storage, release of information, and destruction. A record includes all written clinical information, observations, reports, or fiscal documents relating to a prospective, present, or past consumer, when the creation or retention of those documents is either required or authorized as part of operations. It includes central records, individual consumer records, and reports that may be created. This policy does not apply to the documents that were public before the provider received them, even if the documents now happen to be in the consumer's file (*Legal Reference: 55 PA Code §5100.32(h)*).

This policy explicitly covers all information contained in provider records, including, but not limited to the following: **Note:** All categories should be mentioned within the policy.

- Demographic information.
- Medical treatment information.
- Mental Health treatment information.
- Mental Retardation records/information.
- Child abuse and neglect information.
- Substance Abuse treatment information.
- Contraceptive/Abortion services information, including minors who have received such services without parental knowledge or consent.
- Information received from county children and youth agencies.
- Sexually transmitted disease test results or treatment information.
- HIV information.

If a provider receives a request for information, or needs to release such information for any purposes, a provider may consult this policy and follow it. The specific rules that apply to each piece of information are spelled out in detail below.

Mental Health Treatment Information

Mental Health treatment information is strictly confidential. Parents of children under fourteen (14) years of age and children who are fourteen (14) years of age and older have the right to access patient records and have control over the release of such records. As a result, mental health treatment information may be released if an adult signs a release authorization form. This information may also be released if a child who is fourteen (14) years or older signs such a form. A parent/legal guardian will sign a release for children under fourteen years of age (*Legal Reference*: 55 PA Code §5100.33(a) (b)).

Information may be released without signed authorizations only in the following instances:

- **To those currently providing treatment to the consumer:**
To the extent that they need the information to provide proper care and treatment (*Legal Reference*: 55 P.S. §7111; 55 PA Code §5100.32(a)(1)).
- **To persons at treatment programs or facilities where the consumer is referred:**
For possible treatment, a summary or some of the portion of the treatment information is necessary for the provider to assess the consumer's needs and to assure continuity of proper care and treatment (*Legal Reference*: 55 PA Code § 5100.32(a)(1)).
- **The Director of a County Office of Mental Health and Mental Retardation (or their designee):**
If the information is requested as part of a psychiatric commitment process, i.e., a petition filed under §§ 302, 303, 304, or 305 of the Mental Health Procedures Act (1976). (*Legal Reference*: 55 P.S. §7101 *et seq.* 55 P.S. §7111; 55 PA Code §5100.32(a)(5)).
- **A judge or court in response to a court order:**
Only if the court has actually issued an order directing the release (*Legal Reference*: 55 P.S. §7111; 55 PA Code §5100.32(a)(6) and (7)).
Note: A subpoena is **not** a court order. If a provider receives a subpoena only, check with legal counsel. (*Legal Reference*: 55 PA Code § 5100.35(b)).
- **To lawyers:**
Lawyers who provide written proof that they represent the consumer, which is usually accompanied by a signed authorization (*Legal Reference*: 55 P.S. §7111; 55 PA Code §5100.32(a)(11)).
- **To police or other government officials:**
If an official needs to know if a consumer is present or absent from a particular facility, he/she may only receive information under the following circumstances:
 - the consumer is involuntarily committed to the treatment program AND
 - the request for information occurs as part of a legitimate governmental function AND
 - the only information that can be released is information stating whether the consumer is present or absent in a particular treatment program AND
 - the facility's Medical Director has determined that it is in the best interests of the consumer to release information (*Legal Reference*: 55 PA Code § 5100.32(f)).

If any of the above elements are missing, do not release the information requested.

- **To insurance companies or other third party payers, including CBH:**
If those entities who require information to confirm that the consumer received treatment services for which the company is being requested to pay (here, however, the information that may be released is limited to names, dates, types and costs of therapy and services, and a short description of the general purpose of each treatment session or service (*Legal Reference*: 55 PA Code §5100.32(a)(2)).
- **To physicians, other medical professionals, or police officers:**
If the consumer is involved in a **medical emergency** and the information sought is needed to prevent death or serious risk of bodily harm. Applies to information pertinent to relieving the emergency only (*Legal Reference*: 55 PA Code §5100.32(a)(9)).
 - **Note:** Confidential information that may be disclosed in the case of an emergency **includes** a situation where a psychiatric patient threatens to harm a third party (*Legal Reference*: Ms. B. v. Montgomery County Emergency Service, 799 F.Supp. 534 (E.D. Pa. 1992), aff'd, 989 F.2d 488 (3rd cCir. 1993), cert. den., 114 S.Ct. 174 (1993).
- **To Federal or Commonwealth reviewers and inspectors, and/or participants in peer or utilization reviews.** (*Legal Reference*: (55 PA Code §1101.51(e)):
Commonwealth employees who need treatment information to perform their jobs, JCAHO inspectors, and persons participating in PSRO or utilization reviews (*Legal Reference*: 55 PA Code §§5100.32(4)), 5100.36).
- **To investigators of child or patient abuse:**
When the release is part of an effort to report suspected child abuse, as is required by the Child Protective Services Law. The Child Protective Service Law overrides confidentiality (*Legal Reference*: 11 P.S. §1101 *et seq.*; 55 PA Code §5100.38).
- **To the consumer:**
You may refuse to release information to the consumer only if:
 - The facility Medical Director determines that releasing a portion of the information would be **substantially detrimental** to the consumer's treatment.
 - When revealing a portion of the information would reveal the identity of someone who gave information on the agreement that his or her identity would remain confidential (*Legal Reference*: 55 PA Code §5100.33).
 - If the person is denied access to all or part of his or her record, the denial as well as the basis for it shall be noted in the patient's record.

Mental Retardation Records/Information

This information must be treated the same as mental health treatment information, as it is also strictly confidential. Release of this information normally requires a properly signed release authorization form. There are some differences in who may obtain information without a release. It is always best practice to attempt to obtain a release form; however, information related to an individual's mental retardation may be released, even without a signed authorization form, to:

- The member himself or herself (*Legal Reference*: 55 PA Code §6400.216).
- The member's parent or legal guardian (**Note:** A legal guardian must have a court order documenting their status as legal guardian (*Legal Reference*: 55 PA Code §6400.216)).

- **Note:** Although parents may view records relating to MR services, they **may not** view records or information regarding contraception, abortion, mental health or drug and alcohol services, except under the conditions applicable to those types of information.
- The member’s advocate (*Legal Reference:* 55 PA Code § 6400.216).

Note: The Provider should not release information to any of the persons listed above if the interdisciplinary team documents that disclosure would be detrimental to the member, or if the information sought was provided by someone who did so under an agreement that the information would remain confidential.

Note: If the Provider receives a request for information from any of the other persons listed in the section on mental health treatment information, consult legal counsel.

Child Abuse and Neglect Information

Providers may obtain information about consumers and families who are involved in the child welfare system (also known as the child abuse system, the foster care system, the child neglect system, or the county children and youth system). This information is to be treated the same as information related to mental health treatment and released to persons only under the same conditions that apply to that information.

Substance Abuse Treatment

Various state and federal statutes and regulations guide the confidentiality protocol of substance abuse treatment information. The Commonwealth of Pennsylvania and Federal law regulations allow disclosure of confidential information only when the disclosure will benefit the consumer. The following list of pertinent regulations and statutes are provided to ensure the privacy interests of substance abuse treatment consumers. All Providers and their employees who offer such services are expected to be familiar with said statutes and regulations, and are expected to **strictly adhere** to their contents.

Federal

- 42 C.F.R. Part II (regulation).
- 42 U.S.C. §290ee-3 (drug law).
- 42 U.S.C. §290dd-3 (alcohol law).
- Health Insurance Portability and Accountability Act of 1996.

State

- 28 Pa Code §709.28 (regulation).
- 4 Pa Code §255.5 (regulation).
- 55 Pa Code §5100.37 (regulation).
- 42 Pa Code §6352.1 (PA Act 126).
- 71 P.S. §1690.108 (PA Act 63).

There are only two conditions that allow for the release of information without the consumer's consent: medical emergencies and court orders. Providers may not disclose any information about any patient to anyone outside of the treatment team, except under the following conditions (*Legal Reference*: 42 U.S.C. §290dd-3; 42 C.F.R. (Part II)):

- **Medical emergency:**

If the consumer's life is in immediate jeopardy and requires immediate medical intervention, consumer-identifying information may be disclosed to proper medical authorities solely for the purpose of providing medical treatment to the patient, without the consent of the consumer (*Legal Reference*: 71 P.S. §1690.108(b); 42 C.F.R. Part II, (D)(§2.51)(a)).

- **Court order:**

Consumer identifying information will be released if the court issues an order directing the release (*Legal Reference*: 71 P.S. §1690.108(b); 42 C.F.R. Part II(E), §2.61; 42 Pa Code §6352.1(minors)).

NOTE: When it has been identified that consent is not required, the provider personnel shall:

Legal Reference: 28 Pa Code §709.28(e).

1. Fully document the disclosure in the consumer records.
2. Inform the consumer, as soon as possible, that the information was disclosed, for what purposes, and to whom.

- **Internal communication:**

Restrictions on disclosure in these regulations do not apply to communications of information between or among personnel who have a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for the treatment of alcohol or drug abuse if the communications are: 1) within a program, or 2) between a program and an entity that has direct administrative control over that program. If it is not for this purpose, disclosure is not permitted without the consumer's written consent (*Legal Reference*: 42 C.F.R. Part II §2.12(c)(3)).

Note: Umbrella organizations, such as county human service agencies, hospitals offering many services including drug and alcohol treatment, prisons with drug and alcohol treatment components, may not use the administrative clause to provide identifying information to other services within the umbrella organization where the purpose of the disclosure is not for the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse without the consumer's consent.

- **Non-Consumer Identifying Information:**

Information that cannot be used to identify a particular consumer or group of consumers is not confidential, and is thus releasable.

Consumer identifying information includes, but is not limited to name, address, social security number, fingerprints, photographs, or similar information by which the identity of a consumer can be determined with reasonable accuracy and speed (42 C.F.R. Part II(B), §2.11).

- **Written consent:**

All substance abuse treatment information may be released with an informed and voluntary consent in writing and signed by the consumer. The consent shall be in writing and shall include, but is not limited to: (*Legal Reference:* 28 Pa Code §709.28(c); 42 C.F.R. Part II).

1. Name of the consumer.
2. Name of individual or organization authorized to disclose information.
3. Name of person, agency, or organization to whom disclosure is made.
4. Specific information disclosed.
5. Purpose of disclosure.
6. Dated signature of consumer/guardian following a statement of understanding.
7. Dated signature of witness.
8. Expiration date of the consent.
9. A statement of consent to revoke the release of information.
10. Written notice of prohibition on redisclosure.

Note: Only specific information listed on the informed written consent, in accordance with 42 C.F.R. Part II(C), §2.31 and 28 Pa Code §709.28(c), may be released to the specified recipient. Any information released in excess of that listed on the release form would be a violation of the confidentiality regulations adopted by the Department of Health and Human Services.

- **Qualified service organization agreement:**

Agencies that provide a particular service to drug and alcohol treatment programs or consumers on an ongoing basis may enter into an agreement with a provider to share consumer-identifying information. These agencies include, but are not limited to: data processing, bill collecting, dosage preparation, laboratory analysis, legal services (not criminal justice entities), medical services, accounting services, and training services to consumers to prevent child abuse or neglect such as life skills or child care training (*Legal Reference:* 42 C.F.R., Part II, §2.12(c)(4)).

Note: The service agency will follow the confidentiality requirements of the provider. Managed Care Organizations (MCOs) who only contract with drug and alcohol treatment programs to reimburse the treatment facility for services rendered are not considered a provider of service eligible to enter into a qualified service organization agreement.

- **Research:**

A person conducting research activities may disclose consumer-identifying information obtained through that activity only back to the program from which that information was obtained. Individual consumers may not be identified in any report of the research. Before the researcher is given access to the consumer-identifying information, the program director must approve the purposes of the research via determining if: (*Legal Reference:* 42 C.F.R. Part II, §2.52).

- Has the research and/or evaluation project been approved by the Bureau of Drug and Alcohol programs as stipulated by 4 PA Code §255.7(a)(3)?
- Is the person qualified to conduct the research?
- Is there a research protocol that provides for the security of the information, and does it guarantee that the information will not be redisclosed?

- **Review/Audit:** (*Legal Reference:* 42 C.F.R. Part II, §2.53)

When records are not copied or removed, access may be granted to any person who agrees in writing: to comply with the limitations on redisclosure and use, who performs an audit on behalf of the following entities, and who is determined by the program director to be qualified to conduct the audit or evaluation activity.

- Federal, state, or local governmental agencies providing financial assistance to the program or is authorized by law to regulate the activities of the provider (e.g., Department of Health, Division of Drug and Alcohol Program Licensing).
- Health Maintenance Organizations (HMO), Managed Care Organizations (e.g., CBH, BHSI), insurance companies that provide financial assistance to the program.

Note: A written agreement shall exist between the provider and the reviewers/evaluators before information can be shared. This agreement will include language regarding limitations on redisclosure and use according to 42 C.F.R., Part II. If documents are copied and removed from the facility, the written agreement will include language specifying how the information will be maintained in a confidential manner. When information is removed, the program/agency removing the information is responsible for the security of that information as per 42 C.F.R. Part II, §2.16.

- **Crime on (or threats of) provider premises or against provider personnel:**

Identifying information (consumer status, name, address, last known whereabouts) as well as the circumstances surrounding the incident may be directed to police officers **if** a consumer has committed a crime on provider premises or against provider personnel, or has threatened to commit such a crime (*Legal Reference:* 42 C.F.R. Part II(B), §2.12(c)(5)).

Note: Providers cannot release information about crimes that took place off the premises and did not involve provider personnel or information about past crimes. Unlike mental health treatment facilities, substance abuse treatment providers do not have a duty to warn (i.e., where a specific and immediate threat of serious bodily injury has been conveyed by the consumer to the ‘mental health’ professional regarding a specifically identified or readily identifiable victim). Where a substance abuse treatment center foresees a duty to warn a third party of imminent danger, the procedures indicated at 42 C.F.R. Part II(E), §§2.63 and 2.64 must be followed. In effect, a court order issued by a judge of a court of common please or higher must be obtained.

- **Reporting suspected child abuse or neglect:**

The restrictions on disclosure and use in these regulations do not apply to reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities. However, restrictions of disclosure do apply to the original drug or alcohol abuse consumer records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of a report of suspected child abuse or neglect (*Legal Reference:* 42 C.F.R. Part II(B), §2.12(c)(6)).

Note: If disclosure is made pursuant to the Child Protective Services Law, this information will be documented in the consumer’s chart, and the consumer will be notified of the disclosure (*Legal Reference:* (28 Pa Code §709.28(e)(1)(2)).

- **Minors:**

Minors in Pennsylvania have the legal right to authorize medical care or counseling or services related to the diagnosis or treatment of drug or alcohol abuse or addiction. The consent of the parents or legal guardian of the minor shall not be necessary to authorize medical care or counseling related to such diagnosis or treatment. Such consent shall not be voidable, nor subject to disaffirmance because of minority status (71 P.S. §1690.112 – Act 63). Therefore the minor has the sole authority to consent to the release of records maintained pursuant to counseling and/or medical care (*Legal Reference*: 42 C.F.R. Part II, §2.14(b)).

Note: The State law allows any physician or any agency or organization providing the counseling to inform the parents but does not obligate them to do so.

- **Criminal justice system:**

Although Pennsylvania regulations allow consumer oriented data to be released to certain members of the criminal justice system (i.e., judges, probation/parole officers) without a consumer's consent (*Legal Reference*: 4 Pa Code §255.5(a)(1)(2)(3); 28 Pa Code §709.28(e)), both Federal and State law prohibits the release without written consent (*Legal Reference*: 42 C.F.R. Part II, §2.35(a)(2); 71 P.S. §1690.108(b)). A provider's policy should take the conflict into account and should reflect the State law and Federal regulations that require a consumer's written consent.

Once written consent has been obtained, only the following information may be released (*Legal Reference*: 42 C.F.R. Part II, §2.13(a); 4 Pa Code §255.5(b); 28 Pa Code §709.28(e)):

- Whether or not the consumer is in treatment.
- Prognosis of the consumer.
- The nature of the facility.
- Brief description about the progress of the consumer.
- Short statement as to whether the consumer has relapsed into drug or alcohol abuse and the frequency of such relapses.

Federal regulations and State law supersede the State regulations in requiring that a consent be obtained from the consumer prior to releasing any information to anyone, including Judges, probation/parole officers, insurance companies, health or hospital plans or government officials.

Contraception and Abortion Service Information

Information regarding contraceptive and abortion services are confidential and should not be released without a signed authorization. Confidentiality applies regardless of the age of the consumer.

Sexually Transmitted Disease Information

All records maintained as a result of treatment for sexually transmitted diseases are confidential and cannot be released absent a signed authorization. Certain records of criminal defendants may be releasable during criminal proceedings. Any such request for information against the consumer's wishes should be directed to legal counsel. In addition, the Disease Prevention and Control Law of 1955 generally prohibits State and local health authorities from disclosing reports of diseases or any records maintained pursuant to diagnosis and treatment of communicable diseases, except to a State department of health or local board or department of health for the purpose of prevention or control of communicable diseases (*Legal Reference*: 35 P.S. §521.15).

HIV and AIDS Related Information

Confidential HIV-related information is defined by law as, "any information which is in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV-related information and which concerns whether an individual has been the subject of an HIV-related test, or has HIV, HIV-related illness or AIDS; or any of the information which identifies or reasonably could identify a person as having one or more of these conditions, including information pertaining to the individual's contacts." (*Legal Reference*: 35 P.S. §7603). No person who obtains any of the above information may disclose or be compelled to disclose that information, except to the following persons:

- The consumer.
- The physician who ordered the test, or the physician designee.
- Any persons specifically designated in a written consent.
Note: Every disclosure made by a provider pursuant to a written release will be accompanied by a written statement of limitations on release.
- Medical staff members of a health care provider that have already received confidential HIV-related information, provided they are involved in the medical care of the consumer.
- Federal or State government agencies with oversight responsibilities over health care providers.
- Health care providers providing emergency care of the consumer when information is necessary to provide that care.
- An insurer, to the extent necessary to reimburse health care providers or to make any payment of a claim submitted to an insured person's policy.
- The Commonwealth Department of Health and persons authorized to collect vital statistics.
- The Commonwealth Department of Health and local boards and departments of health authorized to collect information pursuant to the Disease and Prevention Law.
- Persons granted access pursuant to a court order. (**Note:** Prerequisites exist with this exception. Consult legal counsel.)
- Funeral directors.
- Employees of county mental health agencies, county children and youth agencies, county juvenile probation departments, county or state facilities for delinquent youth, and contracted residential providers for the above named entities receiving or contemplating residential placement of a minor consumer who:
 - generally are authorized to receive medical information.
 - are responsible for ensuring that the minor consumer receives proper health care.
 - have a need to know HIV-related information in order to ensure such care is given.

The above named entities may release the information to a court in the course of a dispositional proceeding under 42 PA C.S. §6351 (relating to the disposition of a child) and §6352 (relating to the disposition of a delinquent child) when it is determined that such information is necessary to meet the medical needs of the minor consumer.

Note: Re-disclosure of confidential HIV-related information is generally prohibited unless a written consent is obtained or the above provisions authorize the release. In any event, every disclosure will include a statement regarding re-disclosure. All providers will establish written procedures for confidentiality and disclosure of all HIV-related records (*Legal Reference:* 35 P.S. §7607).

In order to release confidential information, review the case file to determine if a signed authorization for release of confidential information has been obtained. If a signed release is in the file, review the following:

- The authorization covers the information requested
- The authorization is current

If the file does not contain a signed authorization for release of Confidential Information, one must be obtained. The authorization will contain the following:

- Name of the consumer.
- Name of individual or organization authorized to make the disclosure.
- Name of the person, agency, or organization to whom the disclosure will be made.
- Specific information requested.
- Purpose of disclosure.
- Dated signature of the consumer/guardian following a statement of understanding.
- Expiration of consent.
- Revocation statement.
- Written notice of prohibition of re-disclosure.

If the information is requested pursuant to a medical emergency, the following should be done immediately:

- Any person seeking information will identify themselves and provide proof of status as a person who can obtain information without a signed release or court order, i.e., obtain a badge number if a police officer is requesting the information.
- Provide only the information necessary to alleviate an emergency.
- Immediately document in the file what information was provided, to whom, and why.
- Notify the consumer as soon as practicable that the information was released.

Note: If a Provider receives a subpoena seeking confidential information, notify legal counsel. *Do not release any information until legal counsel has been consulted.* The consumer will be notified that confidential information has been subpoenaed.

Note: If a Provider receives a court order directing that confidential information be released, notify legal counsel. *Do not release any information until legal counsel has been consulted.*

Appendix B: Initial Credentialing for Mental Health Staff

Policy: Every member of the staff (professional and paraprofessional) who delivers clinical services and/or supervises the delivery of clinical services to a CBH adult, child and/or adolescent consumer will undergo the process of credentialing. The process is considered an important component in achieving and maintaining the privilege of treating CBH consumers. The position descriptions listed below should serve as guidelines for minimum qualification in each role.

Mental health positions that will be credentialed include:

1. **Medical Director**
2. **Psychiatrist**
3. **Clinical Supervisor**
4. **Clinical Psychologist**
5. **Mental Health Professional (MHP)**
6. **Mental Health Worker (MHW)**
7. **Behavioral Specialist Consultant (BSC)**
8. **Mobile Therapist (MT)**
9. **Therapeutic Support Staff (TSS)**
10. **Therapeutic Support Staff Aide (TSSA)**
11. **Case Manager (CM)**
12. **Targeted Case Manager Supervisor (TCM/ICM)**
13. **Targeted Case Manager (TCM/ICM)**

Medical Director

Minimum requirements for the position include all of the items below:

1. A doctoral degree in medicine or osteopathy from an accredited school of medicine or osteopathy in the United States of America **or** a valid doctoral degree from a foreign school of medicine **and** evidence of successful completion of the E.C.F.M.G. examination (*see*, “Staff Credentialing Files”).
2. A completed psychiatry residency in an A.C.G.M.E. accredited residency program. CBH expects that the Medical Director is an American Board of Psychiatry and Neurology, Inc. diplomate in general psychiatry and/or child and adolescent psychiatry as indicated.
3. A current and valid Pennsylvania medical license.
4. A complete listing of all health care settings wherein privileges have been granted.
5. A listing, upon request, of the location, dates, and reasons for denial/revocation/termination of clinical privileges that have been granted at any and all health care settings.
6. Evidence of a current National Practitioners Data Bank (N.P.D.B.) check.
7. Valid and current D.E.A. certification.
8. Current, good-standing enrollment in the PA Medical Assistance Program.
9. Professional liability insurance with a minimum coverage of \$500,000 per occurrence and \$1,500,000 in the aggregate along with evidence of participation in the PA Medical Care Availability and Reduction of Error (M-CARE) Fund.
10. Three years of administrative experience in community and/or general psychiatry.
11. Compliance with all State and discipline-specific standards and regulations.
12. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
13. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
14. Be employed by the agency no less than twenty (20) hours per week.

Psychiatrist

Minimum requirements for the position include all of the following:

1. A doctoral degree in medicine or osteopathy from an accredited school of medicine or osteopathy in the United States of America **or** a valid doctoral degree from a foreign school of medicine **and** evidence of successful completion of the E.C.F.M.G. examination (*see*, “Staff Credentialing Files”).
2. A completed psychiatry residency in an A.C.G.M.E. accredited residency program. CBH expects that the Medical Director is an American Board of Psychiatry and Neurology, Inc. diplomate in general psychiatry and/or child and adolescent psychiatry as indicated.
3. A current and valid Pennsylvania medical license.
4. A complete listing of all health care settings wherein privileges have been granted.
5. A listing, upon request, of the location, dates and reasons for denial/revocation/termination of clinical privileges that have been granted at any and all health care settings.
6. Evidence of a current National Practitioners Data Bank (N.P.D.B.) check.
7. Valid and current D.E.A. certification.
8. Current, good-standing enrollment in the PA Medical Assistance Program.
9. Professional liability insurance with a minimum coverage of \$500,000 per occurrence and \$1,500,000 in the aggregate along with evidence of participation in the PA Medical Care Availability and Reduction of Error (M-CARE) Fund.
10. Compliance with all state and discipline-specific standards and regulations.
11. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
12. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).

Clinical Supervisor

Minimum requirements for the position:

1. A licensed mental health clinician, including psychiatrists, psychologists, licensed professional counselors (LPC), and licensed clinical social workers (LCSW).
2. If not licensed as defined above, must meet criteria for all items below:
 - Master's Degree from an accredited university in a clinical mental health discipline, such as: Psychology, Counseling, Clinical Social Work, Psychiatric Nursing, and Marriage and Family therapy, for example.
 - Master's Degree must include clinical coursework in the foundations of behavioral health and the provision of mental health services (i.e., individual, group and family therapy, abnormal psychology, psychopathology, cognitive behavioral and psychodynamic therapy, crisis counseling, assessment, child development, personality theory, psychotherapy lab, clinical practicum) Other courses may count as determined by review of transcript/syllabi.
 - In order for a degree to count as a mental health degree, the degree must contain at least twelve (12) credit hours in core behavioral health coursework as defined above. No more than three (3) of these twelve (12) credit hours can be derived from a supervised clinical mental health practicum experience (teaching/education/other non-clinical practicum experiences will not count). Courses such as statistics, program and policy development, and program administration, will not be counted as behavioral health courses because they do not include instruction in the direct provision of mental health services. If coursework is part of a medical degree, there must be clear evidence that the course was directly related to the diagnosis and treatment of mental health disorders rather than medical conditions. Appropriate medical degrees/training will include substantial training in mental health disorders; medical degrees that are behavioral health-related usually include a residency in psychiatry.
3. At least two (2) years verified post-Master's experience providing mental health treatment including psychotherapy, counseling, and assessment. If the supervisor is supervising clinicians treating children, the experience must be with children.

PLUS

4. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
5. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
6. Participation in at least ten (10) hours of documented additional in-service per year ("year" is defined as twelve months after the date of hire).

Clinical Psychologist

Minimum requirements for the position:

1. A Master's Degree from an accredited program.
2. Current and valid Pennsylvania psychology license in good standing.
3. At least two (2) years verified experience providing mental health treatment.

PLUS

4. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
5. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
6. Participation in at least ten (10) hours of documented additional in-service per year ("year" is defined as twelve (12) months after date of hire).

Mental Health Worker

Minimum requirements for the position:

1. Bachelor's Degree from an accredited program in an area of human services, which includes, but may not be limited to the following: sociology, political science, counseling, criminal justice, pastoral counseling, elementary/special education of family therapy, **and**, a minimum of one (1) year direct care experience or supervised practice in lieu of the experience requirement.

OR

2. Two (2) years direct care experience and high school diploma (or equivalency) plus twelve (12) semester credit hours from an approved educational program.

PLUS

3. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
4. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
5. Participation in at least ten (10) hours of documented additional in-service per year ("year" is defined as twelve (12) months after date of hire).

Mental Health Professional

If not licensed as defined above, must meet criteria for all items below:

1. Master's Degree from an accredited university in a clinical mental health discipline, such as: Psychology, Counseling, Clinical Social Work, Psychiatric Nursing, and Marriage and Family therapy, for example. The Master's Degree must include clinical coursework in the foundations of behavioral health and the provision of mental health services (i.e., individual, group and family therapy, abnormal psychology, psychopathology, cognitive behavioral and psychodynamic therapy, crisis counseling, assessment, child development, personality theory, psychotherapy lab, clinical practicum). Other courses may count as determined by a review of the transcript/syllabi.
2. In order for a degree to count as a mental health degree, the degree must contain at least (12) credit hours in core behavioral health coursework as defined above. No more than three (3) of these twelve (12) credit hours can be derived from a supervised clinical mental health practicum experience (teaching/education/other non-clinical practicum experiences will not count). Courses such as statistics, program and policy development, and program administration, will not be counted as behavioral health courses because they do not include instruction in the direct provision of mental health services. If coursework is part of a medical degree, there must be clear evidence that the course was directly related to the diagnosis and treatment of mental health disorders rather than medical conditions. Appropriate medical degrees/training will include substantial training in mental health disorders; medical degrees that are behavioral health-related usually include a residency in psychiatry.
3. At least two (2) years verified experience in the mental health field.

PLUS

4. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
5. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
6. Participation in at least ten (10) hours of documented additional in-service per year ("year" is defined as twelve (12) months after date of hire).

Note: All **BHRS** positions will defer to Department of Public Welfare (DPW) Criteria when DPW criteria are more stringent.

Behavioral Specialist Consultant (BSC)

Minimum requirements for the position:

1. Mental health clinician with current Pennsylvania licensure as a Psychologist.
 - **Note:** Licensed psychologists will not be required to demonstrate coursework or behavior modification training; psychologists should adhere to the American Psychological Association's guidelines for clinical supervision; training is required as listed below.

2. If not licensed as above, must meet criteria for all items below: Master's Degree from an accredited university in a clinical mental health discipline such as: Psychology, Counseling, Clinical Social Work, Psychiatric Nursing, and/or Marriage and Family therapy. Degree must include clinical coursework in the foundations of behavioral health and the provision of mental health services (e.g., individual, group and family therapy, cognitive behavioral therapy, psychodynamic therapy, crisis counseling, abnormal psychology, psychopathology, assessment, child development, personality theory, psychotherapy lab, clinical practicum). Other courses may be considered as determined by a transcript/syllabi review. For a degree to count as a mental health degree, the degree must contain at least twelve (12) credit hours in core behavioral health coursework as defined above. No more than three (3) of these twelve (12) credit hours can be derived from a supervised clinical mental health practicum experience (teaching/education/non-clinical practicum experiences will not count). Courses such as statistics, program and policy development, and program administration will not be counted as behavioral health courses because they do not include instruction in the direct provision of mental health services. If coursework is part of a medical degree, there must be clear evidence that the course was directly related to the diagnosis and treatment of mental health disorders rather than medical conditions. Appropriate medical degrees/training will include substantial training in mental health disorders; medical degrees that are behavioral health-related usually include a residency in psychiatry.
3. Training in behavior analysis/modification (minimum of eight (8) hours prior to hire, eight (8) hours annually thereafter).
4. Regular/documented clinical supervision by a licensed psychologist.
5. Two (2) years verified post-Master's experience providing mental health treatment to children, and at least one (1) year experience using behavior analysis/modification techniques.
6. Any additional education, training or supervision requirements stipulated by the Department of Public Welfare within Medical Assistance Bulletins. **Note:** In preparation for the Department of Public Welfare potentially requiring all BSCs to be certified in Applied Behavioral Analysis. CBH will only recognize those Applied Behavioral Analysis programs that are certified and approved by the Behavior Analyst Certification Board, Inc (www.bacb.com). CBH will also require individual BSCs to be certified through the Behavior Analyst Certification Board once they have completed the required coursework/training.

PLUS

7. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
8. Participation in and completion of the CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
9. Participation in at least ten (10) hours of documented additional in-service per year ("year" is defined as 12 months after date of hire; Behavior modification training can count toward these hours if it is offered after hire).

Mobile Therapist (MT)

Minimum requirements for the position:

1. A licensed mental health clinician, including psychiatrists, psychologists, licensed professional counselors (LPC), and/or licensed clinical social workers (LCSW) (licensed clinicians as defined above will not be required to demonstrate coursework or experience requirements; supervision requirements should be determined by the licensing body; training is required as described below).
2. If not licensed as defined above, must meet criteria for all items below: Master's Degree from an accredited university in a clinical mental health discipline, such as: Psychology, Counseling, Clinical Social Work, Psychiatric Nursing, and Marriage and Family therapy, for example. The degree must include clinical coursework in the foundations of behavioral health and the provision of mental health services, i.e. individual, group and family therapy, cognitive behavioral therapy, psychodynamic therapy, crisis counseling, abnormal psychology, psychopathology, assessment, child development, personality theory, psychotherapy lab, clinical practicum, etc. Other courses may qualify as determined by review of transcript/syllabi. In order for a degree to count as a mental health degree, the degree must contain at least (12) credit hours in core behavioral health coursework as defined above. No more than three (3) of these twelve (12) credit hours can be derived from a supervised clinical mental health practicum experience (teaching/education/other non-clinical practicum experiences will not count). Courses such as statistics, program and policy development, and program administration, will not be counted as behavioral health courses because they do not include instruction in the direct provision of mental health services. If coursework is part of a medical degree, there must be clear evidence that the course was directly related to the diagnosis and treatment of mental health disorders rather than medical conditions. Appropriate medical degrees/training will include substantial training in mental health disorders; medical degrees that are behavioral health-related usually include a residency in psychiatry. *Mobile Therapists must have formal training in the provision of psychotherapy.*
3. At least one (1) year verified post-Masters experience providing psychotherapy/counseling to children.
4. Regular/documented clinical supervision from a supervisor meeting the criteria for Clinical Supervisor.
5. Any additional education, training or supervision requirements stipulated by the Department of Public Welfare within Medical Assistance Bulletins.

PLUS

6. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
7. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and then annually from the date of the initial training).
8. Participation in at least ten (10) hours of documented additional in-service per year ("year" is defined as twelve (12) months after date of hire).

Therapeutic Support Staff (TSS)

Minimum requirements for the position:

TSS workers must meet the Department of Public Welfare requirements listed in Medical Assistance Bulletin (#01-01-05), as follows:

1. Bachelor's degree in one (1) of the following disciplines: Psychology, Social Work, Sociology, Education, Criminal Justice, or other Human Service field. If one of the above degrees is held, no work experience is required. If the worker is a Licensed Registered Nurse, 1 year verified full-time paid experience working in direct contact with children/adolescents is required.
"Other" Bachelor's: 1 year verified full-time paid experience* working in direct care with children/adolescents is required.

OR

2. Associate's degree or 60 Credits toward a bachelor's degree, or a Licensed Practical Nurse with three (3) years verified full-time paid work experience working in direct contact with children/adolescents is required.

* Note that if a practicum was required for the degree, it cannot be counted as work.

* Full-time work with children/adolescents means: MH, MR, early intervention, children & youth, juvenile justice system, education, drug & alcohol, daycare or health systems.

3. Training Requirements: For TSS hired after 7/1/01 with no prior TSS experience, one must have 15 hours of training PRIOR to working alone with child/adolescent and within the first six (6) months of hire, must have an additional twenty four (24) hours of training. For TSS hired before 7/1/01, one must have twenty (20) hours of training by 7/1/02.

Note: The Training curriculum must include at least the following topics: Professional ethics, conduct, and legal issues, including Child Protective Services, mandated reporting and confidentiality; Understanding CAASP principles, implementing and supporting those principles in actual practice; role of TSS worker in home, school, community, including the use of community resources to support the child/family; crisis intervention; behavior management and safety; overview of serious emotional disturbance and other behavior needs in child/adolescent with emphasis on diagnosis; collaboration with families; normal child/adolescent development; behavior management skills; CPR, first aid, universal precautions & safety; documentation skills; Psychotropic medications and side effects.

4. TSS workers hired after 7/1/01 must receive on-site assessment and assistance supervision by a supervisor who meets the criteria for Clinical Supervisor in the environment where services are being provided, *before* working alone with a child. Workers with less than six (6) months of previous TSS experience must receive six (6) hours of on-site assessment & assistance by a qualified supervisor; more than six (6) months TSS experience, one must have three (3) hours of assessment/assistance.
5. All TSS workers shall receive *weekly* supervision by a supervisor meeting the qualifications of a Clinical Supervisor, as follows: TSS' working twenty (20) hours or more per week require one (1) hour of supervision per week; TSS' working less than twenty (20) hours need one half (.5) hour of supervision per week. All TSS supervision should include periodic on-site supervision and a full case review of all cases at least once per month.

PLUS

6. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
7. Participation in and completion of all CBH mandatory in-services (must be completed with three (3) months of hire and then annually from the date of the initial training).
8. Participation in at least ten (10) hours of documented additional in-service per year (ongoing TSS training, as defined above, can count toward this requirement; “year” is defined as twelve (12) months after date of hire).

Therapeutic Support Staff Aide (TSSA)

Minimum requirements for the position:

1. High school diploma or G.E.D., and be at least twenty-one (21) years of age.
2. At least two (2) years of verified volunteer or paid work experience with children.

PLUS

3. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
4. Participation in the mandatory pre-service training totaling twenty (24) hours. Mandatory pre-service training must include the following topics: Children’s mental health issues, children’s developmental issues, cultural competence, families as partners, CASSP principles, fire safety and accident prevention concepts, universal precautions, crisis prevention, management and passive restraint training, managing boundaries, transportation and related issues, CPR/first aid, psychotropic medications/behavioral medication (for non-medical personnel), mandated reporting laws (child abuse and neglect), behavior modification techniques, documentation and confidentiality.
5. Participation in and completion of all CBH mandatory in-services (must be completed with three (3) months of hire and then annually from the date of the initial training).
6. Participation in ongoing training of twenty (20) hours per year covering topics required for TSS workers as listed above.
7. TSS Aides who work twenty (20) hours or less must receive one (1) hour per week of individual supervision; TSS Aides working more than twenty hours per week must receive two (2) hours per week of supervision by a supervisor meeting criteria for Clinical Supervisor. At least one (1) hour per week must be individual supervision.

Case Manager

Minimum requirements for the position:

1. A Bachelor's Degree from an accredited university.
2. One (1) year verified experience in case management or counseling with children and families, or is a licensed registered nurse with one (1) year experience.

PLUS

3. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
4. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
5. Participation in at least ten (10) hours of documented additional in-service per year ("year" is defined as 12 months after date of hire).

Targeted Case Manager (ICM) Supervisor (55 Pa Code §5221.21(2))

Overall supervision of the intensive case management unit, as well as individual supervision of intensive case managers, shall be carried out only by a mental health professional [*Legal Reference*: 55 Pa Code §5221.21(2)].

Intensive case managers who are mental health professionals shall have one (1) of the following:

1. A Master's degree in social work, psychology, rehabilitation, activity therapies, counseling, or education and three (3) years mental health direct care experience [*Legal Reference*: 55 Pa Code §5221.21(2)(i)].
2. A Bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education, or be a registered nurse, and five (5) years mental health direct care experience, two (2) of which shall include supervisory experience [*Legal Reference*: 55 Pa Code §5221.21(2)(ii)].
3. A Bachelor's degree in nursing and three (3) years mental health direct care experience [*Legal Reference*: 55 Pa Code §5221.21(2)(iii)].

PLUS

4. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
5. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
6. Participation in at least ten (10) hours of documented additional in-service per year.

Targeted Case Manager (ICM) (55 Pa Code §5221.21(3))

Intensive case managers who are not mental health professionals shall have one (1) of the following:

1. A Bachelor's degree with major course work in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education [*Legal Reference*: 55 Pa Code §5221.21(3)(i)(a)].
2. Be a registered nurse [*Legal Reference*: 55 Pa Code §5221.21(3)(i)(b)].
3. A high school diploma and twelve (12) semester credit hours in sociology, social welfare, psychology, gerontology or other social science and two (2) years experience in public or private human services with one (1) year in direct client contact [*Legal Reference*: 55 Pa Code §5221.21(3)(i)(c)].
4. A high school diploma and five (5) years of mental health direct care experience in public and private human services with employment as an intensive case management staff person prior to April 1, 1989 [*Legal Reference*: 55 Pa Code §5221.21(3)(i)(d)].
5. Be supervised by a mental health professional (*as described above*). A record of supervision shall be on file [*Legal Reference*: 55 Pa Code §5221.21(3)(ii)].

PLUS

6. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
7. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
8. Participation in at least ten (10) hours of documented additional in-service per year.

Appendix C: Initial Credentialing for Drug and Alcohol Services Staff

Policy: Every member of the staff (professional and paraprofessional) who delivers clinical services and/or supervises the delivery of clinical services to a CBH consumer must be in compliance with staff qualifications as mandated by **28 Pa Code §704**. This chapter applies to project directors, facility directors, clinical supervisors, counselors, and counselor assistants hired or promoted on or after March 4, 1996 (*Legal Reference:* 28 Pa Code §704.4(a)). To ensure compliance, each staff member will undergo the process of credentialing. The process is considered an important component in achieving and maintaining the privilege of treating CBH consumers. The position descriptions listed below should serve as guidelines for minimum qualification in each role.

Drug and Alcohol positions that will be credentialed include:

1. **Medical Director**
2. **Project Director/Facility Director**
3. **Case Manager**
4. **Substance Abuse Clinical Supervisor**
5. **Substance Abuse Counselor**
6. **Substance Abuse Counselor Assistant**
7. **Substance Abuse Assessor**

Medical Director

Minimum requirements for the position:

1. A doctoral degree in medicine or osteopathy from an accredited school of medicine or osteopathy in the United States of America **or** a valid doctoral degree from a foreign school of medicine **and** evidence of successful completion of the E.C.F.M.G. examination (*see*, “Staff Credentialing Files”).
2. A completed psychiatry residency in an A.C.G.M.E. accredited residency program. CBH expects that the Medical Director is an American Board of Psychiatry and Neurology, Inc. diplomate in general psychiatry and/or child and adolescent psychiatry as indicated.
3. A current and valid Pennsylvania medical license.
4. A complete listing of all health care settings wherein privileges have been granted.
5. A listing, upon request, of the location, dates, and reasons for denial/revocation/termination of clinical privileges that have been granted at any and all health care settings.
6. Evidence of a current National Practitioners Data Bank (N.P.D.B.) check.
7. Valid and current D.E.A. certification.
8. Current, good-standing enrollment in the PA Medical Assistance Program.
9. Professional liability insurance with a minimum coverage of \$500,000 per occurrence and \$1,500,000 in the aggregate along with evidence of participation in the PA Medical Care Availability and Reduction of Error (M-CARE) Fund.
10. Three years of administrative experience in community and/or general psychiatry.
11. Compliance with all State and discipline-specific standards and regulations.
12. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
13. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
14. Be employed by the agency no less than twenty (20) hours per week.

Project/Facility Director (28 Pa Code §704.5)

Minimum requirements for the position (must satisfy one of the following):

1. Master's Degree, or above, from an accredited college with a major in medicine, chemical dependency, psychology, social work, law, human service administration, counseling, nursing (with a specialty in nursing/health administration, nursing/counseling education, or a clinical specialty in the human services), public administration, business management, or other related fields, *and* two (2) years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service, and program planning (*Legal Reference: 28 Pa Code §704.5(c)(1)*).
2. Bachelor's Degree from an accredited college which meets the requirements of the above specialty areas *and* three (3) years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct services, and program planning (*Legal Reference: 28 Pa Code §704.5(c)(2)*).
3. Associate Degree from an accredited college which meets the requirements of the above specialty areas *and* four (4) years of experience in a human services agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service, and program planning (*Legal Reference: 28 Pa Code §704.5(c)(3)*).
4. Current licensure in this Commonwealth as a physician *and* two (2) years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service, and program planning.
5. Current licensure in the Commonwealth as a psychologist *and* two (2) years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service, and program planning.
6. Current licensure as a social worker *and* two (2) years of experience in a human service agency, preferably in a drug and alcohol setting, which includes supervision of others, direct service, and program planning.

PLUS

7. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
8. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
9. Participation in at least ten (10) hours of documented additional in-service per year.

Case Manager

Minimum requirements for the position (must satisfy one of the following):

1. M.D. or D.O. from an accredited school of medicine or osteopathy in the United States of America **or** a valid M.D. from a foreign school of medicine and evidence of successful completion of the E.C.F.M.G. examination (*see*, “Staff Credentialing Files”).

OR

2. Master's Degree, or above, from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services), or other related field, which includes a practicum in a human service agency, preferably in a drug and alcohol setting.

OR

3. Bachelor's Degree from an accredited college which meets the requirements of the above specialty areas *and* one year of clinical experience (a minimum of 1,820 documented hours) in a human service agency, preferably in a drug and alcohol setting.

OR

4. Associate Degree from an accredited college that meets the requirements of the above specialty areas *and* two years of clinical experience (a minimum of 3,640 documented hours) in a human service agency, preferably in a drug and alcohol setting.

OR

5. Current license in Pennsylvania as a registered nurse and a degree from an accredited school of nursing *and* one year of counseling experience (a minimum of 1,820 documented hours) in a health or human service agency, preferably in a drug and alcohol setting.

OR

6. Full certification as an addictions counselor by a statewide certification body which is a member of a national certification body, or certification by another state government’s substance abuse counseling certification board.

PLUS

7. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
8. Participation in at least ten (10) hours of documented additional in-service per year.

Substance Abuse Clinical Supervisor (28 Pa Code §704.6)

Minimum requirements for the position (must satisfy **one** of the following):

1. Master's Degree or above from an accredited university/college with a major in medicine, chemical dependency, art therapy, dance therapy, human development and family studies, special education, sociology, counselor education, human behavior, Individual and Family Studies, Pastoral studies, music therapy, psychology, social work, nursing (with a clinical specialty in administration or human services), *and* two (2) years of clinical experience in a health or human services agency which includes one (1) year of working directly with the chemically dependent (**Legal Reference:** 28 Pa Code §704.6(b)(1)).
2. Bachelor's degree from an accredited university/college which meets the requirements of the above specialty areas *and* three (3) years of clinical experience in a health or human service agency, which includes one (1) year of working directly with the chemically dependent (**Legal Reference:** 28 Pa Code §704.6(b)(2)).
3. Associate Degree from an accredited university/college which meets the requirements of the above specialty areas *and* four (4) years of clinical experience in a health or human services agency which includes one (1) year of working directly with the chemically dependent (**Legal Reference:** 28 Pa Code §704.6(b)(3)).
4. Full certification as an Addictions Counselor by a statewide certification body which is a member of a national certification body or certification by another state government's substance abuse counseling certification board *and* three (3) years of clinical experience in a health or human service agency which includes one (1) year of working directly with the chemically dependent. The individual shall also complete a Department approved core curriculum training that includes a component on clinical supervision skills (**Legal Reference:** 28 Pa Code §704.6(b)(4)).

PLUS

5. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
6. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
7. Participation in at least ten (10) hours of documented additional in-service per year.

Substance Abuse Counselor (28 Pa Code §704.7)

Minimum requirements for the position (must satisfy one of the following):

1. Current licensure in this Commonwealth as a physician (*Legal Reference:* 28 Pa Code §704.7(b)(1)).
2. Master's Degree or above from an accredited university/college with a major in chemical dependency, psychology, art therapy, dance therapy, human development and family studies, special education, sociology, counselor education, human behavior, Individual and Family Studies, Pastoral studies, music therapy, social work, nursing (with a clinical specialty in the human services), or other related field, which includes a practicum in a health or human service agency, preferably in a drug and alcohol setting. If the practicum, did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues (*Legal Reference:* 28 Pa Code §704.7(b)(2)).
3. Bachelor's Degree from an accredited university/college which meets the requirements of the above specialty areas *and* one (1) year of clinical experience (a minimum of 1,820 documented hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues (*Legal Reference:* 28 Pa Code §704.7(b)(3)).
4. Associate Degree from an accredited university/college which meets the requirements of the above specialty areas *and* two (2) years of clinical experience (a minimum of 3,640 documented hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues (*Legal Reference:* 28 Pa Code §704.7(b)(4)).
5. Current licensure in this Commonwealth as a registered nurse and a degree from an accredited school of nursing *and* one (1) year of counseling experience (a minimum of 1,820 documented hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues (*Legal Reference:* 28 Pa Code §704.7(b)(5)).
6. Full certification as an addictions counselor by a statewide certification body which is a member of a national certification body, or certification by another state government's substance abuse counseling certification board (*Legal Reference:* 28 Pa Code §704.7(b)(6)).

PLUS

7. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
8. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
9. Participation in at least ten (10) hours of documented additional in-service per year.

Substance Abuse Counselor's Assistant (28 Pa Code §704.8)

A person who does not meet the educational and experiential qualifications for the position of counselor may be employed as a counselor assistant if the requirements of at least one (1) of the following paragraphs are met. However, a project may not hire more than one (1) counselor assistant for each employee who meets the requirements of clinical supervisor or counselor (*Legal Reference:* 28 Pa Code §704.8(a)). The minimum requirements for the position (must satisfy one of the following):

1. Master's Degree in a human service area (*see substance abuse counselor, above*) (*Legal Reference:* 28 Pa Code §704.8(a)(1)).
2. Bachelor's Degree in a human service area (*see substance abuse counselor, above*) (*Legal Reference:* 28 Pa Code §704.8(a)(2)).
3. Associate Degree in a human service area (*see substance abuse counselor, above*) (*Legal Reference:* 28 Pa Code §704.8(a)(4)).
4. Current license in Pennsylvania as a registered nurse (*Legal Reference:* 28 Pa Code §704.8(a)(3)).
5. A high school diploma or General Education Development (GED) equivalent (*Legal Reference:* 28 Pa Code §704.8(a)(5)).

PLUS

6. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
7. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
8. Participation in at least ten (10) hours of documented additional in-service per year.

Note: A full-time clinical supervisor or full-time counselor will supervise a counselor assistant in accordance with 29 Pa Code §704.9 (*See also, Division of Drug and Alcohol Program Licensure Licensing Alert, 4-02, dated October 2002*). The position of Counselor Assistant may be a permanent position. There should be no more than one counselor's assistant position for each Substance Abuse Counselor employed by the provider. A counselor assistant shall also complete the training requirements in 28 Pa Code §704.11 (relating to staff development).

Substance Abuse Assessor

The minimum requirements for the position (must satisfy **one** of the following):

1. Trained in Pennsylvania's Consumer Placement Criteria for Adults (PCPC) and the Adolescent A.S.A.M.
2. Bachelor's or Master's Degree from an accredited college with a major in dependency, psychology, social work, nursing, or other related fields with one (1) year of experience in a drug and alcohol treatment program as a counselor.
3. Associates Degree from an accredited college with a major in dependency, psychology, social work, nursing (with a specialty in the human services), or other related field with a minimum of two full years (3,640 hours) in the last five (5) working in a drug and alcohol treatment program as a counselor.
4. Completion of six (6) hours of training within the past five (5) years in each of the following six (6) areas:
 - Drug and alcohol assessment.
 - The disease of addiction.
 - Treatment approaches.
 - Pharmacology.
 - Confidentiality.
 - Interaction of addiction and mental illness.
5. Consistent with state staffing regulations for counselors, each assessor will complete at least twenty-five (25) hours of training annually. In the first year following credentialing as an assessor, eighteen (18) of those twenty-five (25) hours are to be done at the rate of six (6) hours of training in each of the following three (3) areas:
 - Cultural awareness/gender issues.
 - Developmental psychology.
 - Medical/physical/HIV issues.

PLUS

6. Participation in and completion of all CBH mandatory in-services (must be completed within three (3) months of hire and annually from the date of the initial training).
7. Valid Child Abuse (Act 33) (*when applicable*), Criminal History, and FBI clearances (*when applicable*).
8. Participation in at least ten (10) hours of documented additional in-service per year.

Note: The balance of training hours in year one, along with any subsequent years' training requirements, will be in the above areas and in any additional as identified by the provider. Specialized training should also be required for specific assessment and level of care placement tools employed as components of the provider's assessment process.

Appendix D: Criminal History Record Repositories

The following is a courtesy list of all of the known criminal history record repositories within the United States. This is just a reference, and it is the Provider's responsibility to call the respective agencies for confirmation of the information contained herein. It is recommended that agencies that are not able to secure a FBI clearance should obtain state-specific criminal histories (*where possible*) for those employees who have resided, worked, or gone to school outside of the state of Pennsylvania for any period of time over (1) year.

SASE: self addressed stamped envelope
PC: personal check

BC: business check MO: money order
CC: certified check/cashiers check

ALABAMA

Alabama Bureau of Investigation Identification Unit
P.O. Box 1511
Montgomery, Alabama 36102-1511
Phone: 334-242-4244
Fee: \$25.00, mo, cc

ALASKA

Dept. of Public Safety Records & Identification
5700 East Tudar Road
Anchorage, AK 99507
Phone: 907-269-5765
Fee: \$35.00, payable to State of Alaska,
pc,mo,cc. Fingerprints required.

ARIZONA

Does not provide criminal history clearances.

ARKANSAS

Arkansas State Police
Attn: ID Bureau
#1 State Police Plaza Drive
Little Rock, AR 72209
Phone: 501-618-8500
Fee: \$15.00, pc, mo, cc. Include SASE.

CALIFORNIA

Does not provide criminal history clearances.

CANADA

Royal Canadian Mounted Police
6080 Riverside Drive, E.
Windsor Ontario, N8S1B6
Phone: 519-948-5287 Fax: 519-948-5289
Fee: None.

COLORADO

CO Bureau of Investigation
Crime Information Center
6900 Kipling Street, #3000
Denver, CO 80215
Phone: 303-239-4208
Fee: \$10, bc, mo, cc

Instructions: Must request form, when received include this statement: "This statement shall not be used for the direct solicitation of business for pecuniary gain." Sign and date this statement.

CONNECTICUT

State Police Bureau of Identification
P.O. Box 2794
Middletown, CT 06459-9294
Phone: 860-685-8480
Fee: \$25.00, payable to Comm. of Public Safety, pc, mo, cc. Call for form DPS-846-C or search www.state.ct.us/dps. Include SASE.

DELAWARE

State Police Headquarters
Attn: S.B.I., P.O. Box 430
Dover, DE 19903-0430
Phone: 302-739-2134
Fee: \$30.00, pc (by mail only), mo, cc.
Fingerprints required. Contact for release forms & fingerprint card.

DISTRICT OF COLUMBIA

Metropolitan Police Department
ID/Records Division, Room 3061
300 Indiana Avenue, N.W.
Washington, DC 20001
Phone: 202-727-4245
Fee: \$5.00, PAYABLE TO dc Treasurer, mo, cc, include SASE, application & notarized release form.

FLORIDA

FL Dept. of Law Enforcement
Attn: Criminal Record Inquiry
P.O. Box 1489
Tallahassee, FL 32302
Phone: 850-410-8109
Fee: \$15.00, pc, mo, cc.
Written request only, include SASE.

HAWAII

Hawaii Criminal Justice Data Center
465 South King Street
Honolulu, HI 96813
Phone: 808-587-3100
Fee: \$10.00, mo, cc

ILLINOIS

Illinois State Police Processing Unit
Bureau of Identification
260 North Chicago
Joliet, IL 60431-1060
Phone: 815-740-5164
Fee: \$12.00, pc, mo, cc

IOWA

Iowa Division of Criminal Investigation
Bureau of Identification
Wallace State Office Building
502 East 9th Street
Des Moines, IA 50319-0041
Phone: 515-281-4776
Fee: \$13.00 pc, mo, cc. Contact for release forms.

KENTUCKY

Kentucky State Police
Records Section
1250 Louisville Road
Frankfort, KY 40601
Phone: 502-227-8713
Fee: \$10.00, payable to Kentucky State Treasurer, pc
Mo, cc. Must submit written request.

GEORGIA

GA Crime Information Center
AFIS/ Applicant Team
P.O. Box 370748
Decatur, GA 30037-0748
Attn: Jackie James
Phone: 404-244-2890
Fee: \$15.00 mo, cc. Must order 2 fingerprint
Cards for \$1.00 (mo,cc) and return them before
crim. history is released. OAC# GAP103432 to
be listed on fingerprint card. Results mailed
directly to employer.

IDAHO

Idaho Bureau of Criminal ID
P.O. Box 700
Meridian, ID 83680-0700
Phone: 208-884-7130
Fee: \$10.00, pc, mo, cc. Fingerprints required.
Include letter of release and SASE.

INDIANA

Indiana State Police
Indiana Gov't Center, North Building
Central Records Division
100 North Senate Ave., Room N302
Indianapolis, IN 46202
Phone: 317-232-8262. Fee: \$10.00, mo, cc
Must submit written request w/reason for re-
quiring information. Fingerprints required.

KANSAS

Kansas Bureau of Investigation
1620 Southwest Tyler
Topeka, KS 66612-1837
Phone: 785-296-8200
Fee: \$10.00 certified copy, mo, cc, pc. Include
SASE.

LOUISIANA

Does not provide criminal history clearances

MAINE

Maine State Police
 Bureau of Identification
 36 Hospital Street
 Augusta, ME 04330-6514
 Phone: 207-624-7009
 Fee: \$8.00, payable to Treasurer, State of Maine
 pc, mo, cc. Must submit written request w/name
 (including previous names), DOB, and reason for
 requesting information. Include SASE.

MICHIGAN

Michigan State Police
 Central Records Division
 Identification Section
 7150 Harris Drive
 Lansing, MI 48913
 Phone: 517-322-5531
 Fee: \$5.00, payable to State of Michigan, pc, mo,
 cc. Submit written request. Must include name, DOB,
 race, sex, & ss#.

MISSISSIPPI

Does not provide criminal history clearances.

MONTANA

Montana Identification Bureau
 Attn: Criminal History Records
 303 North Roberts Road, 3rd Floor, Room 374
 Helena, MT 59620
 Phone: 404-444-3625
 Fee: \$5.00, mo, cc. Must submit written request for
 Name search w/name (including all previous names),
 ss#, and DOB. Include SASE.

NEVADA

Nevada Highway Patrol Records & Identification
 808 West Nye Lane
 Carson City, NV 89703
 Phone: 775-687-1600
 Fee: \$15.00, payable to Nevada Highway Patrol, mo,
 cc. Fingerprints required (use any fingerprint card).

NEW JERSEY

NJ State Police Criminal Information Unit
 P.O. Box 7068, West Trenton, NJ 08628-0068
 Phone: 609-882-2000. Fingerprints required
 Fee: \$25, payable to NJ State Police-SBI, mo, cc

MARYLAND

CJIS – Central Repository
 PO Box 32708
 Pikesville, MD 21282-2708
 Phone: 410-764-4501
 Fee: \$18.00, mo, cc. Fingerprints required.
 Contact for release forms & fingerprint cards.

MASSACHUSETTS

Criminal History Systems Board
 CORI Unit
 Phone: 617-660-4640
 Contact and request “Personal Criminal History
 Form.” Fee: \$0

MINNESOTA

Dept. of Public Safety
 Bureau of Criminal Apprehension
 Attn: CCH/ID
 1246 University Avenue
 St. Paul, MN 66104-4197
 Phone: 651-642-0670
 Fee: \$15.00, mo, cc. Include SASE.

MISSOURI

State Highway Patrol
 Criminal Records and Identification Division
 1510 East Elm, P.O.B. 568
 Jefferson City, MO 65102
 Phone: 573-526-6153
 Fee: \$14.00, pc, mo, cc

NEBRASKA

State Patrol Headquarters
 Attn: CID Division
 P.O. Box 94907
 Lincoln, NE 68509-4907
 Phone: 402-479-4924 or 402-479-4978
 Fee: \$10.00, mo, cc.

NEW HAMPSHIRE

New Hampshire Department of Safety
 Div. of State Police Central Repository for
 Criminal Records
 10 Hazen Drive, Concord, NH 03305
 Phone: 603-271-2538
 Fee: \$10, payable to State of NH Crim.Records
 Submit form DSSP256, on www.state.nh.us/nhsp

NEW MEXICO

NM Dept. of Public Safety
Records Bureau
P.O. Box 1628
Sante Fe, NM 87504-1628
Phone: 505-827-9181
Fee: \$5.00, w/their authorization form, signed &
Notarized, cash, mo, cc. Contact for authorization
form.

NORTH CAROLINA

Does not provide criminal history clearances.

OHIO

Bureau of Criminal Identification
P.O. Box 365
London, OH 43140
Phone: 740-845-2000
Fee: \$15.00, pay to Treasurer of the State of Ohio
Mo, cc. Fingerprints required, use #BII-241 on
fingerprint card.

OREGON

Oregon State Police
P.O. Box 4395
Portland, OR 97208-4395
Attn: AFIF Unit 11
Phone: 503-378-3070, ext. 330
Fee: \$12.00, mo, cc. Fingerprints required.

RHODE ISLAND

Department of the Attorney General
150 South Main Street
Providence, RI 02903
Phone: 401-274-4400 (Ask for BCI Unit).
Fe: \$5.00, payable to Attorney General. Send
notarized release request & notarized copy of
official identification.

SOUTH DAKOTA

Division of Criminal Investigation
500 East Capitol
Pierre, SD 57501-5070
Phone: 605-773-3331
Fee: \$15.00, pc, mo, cc, Contact for release form
and fingerprint cards.

NEW YORK

Record Review Unit
N.Y. State Division of Criminal Justice Services
4 Tower Place
Albany, NY 12203-3764
Phone: 518-485-7675
Fee: \$25.00, payable to NY State Division of
Criminal Justice Services. Contact for
informational packet and fingerprint cards.

NORTH DAKOTA

Criminal Investigations
Office of Attorney General
P.O. Box 1054
Bismarck, ND 58502-1054
Phone: 701-328-5500
Fee: \$20.00, pay to ND Attorney General, pc,
mo, cc

OKLAHOMA

Oklahoma State Bureau of Investigation
Criminal History Reporting Unit
6600 N. Harvey St., Bldg. 6, Ste. 300
Oklahoma City, OK 73116
Phone: 405-848-6724
Fee: \$15.00, mo, cc. Fingerprints required.
Include SASE.

PENNSYLVANIA

Director, Records/ID Division
Attn: Central Repository
1800 Elmerton Avenue
Harrisburg, PA 17110
Phone: 717-783-9144 or 717-783-9973
Fee: \$10.00, pc, mo, cc.

SOUTH CAROLINA

South Carolina Law Enforcement
Attn: Central Records Repository
P.O. Box 21398
Columbia, SC 29221-1398
Phone: 803-737-9000
Fee: \$25.00, bc, mo, cc. Include SASE.

TENNESSEE

Does not provide criminal history clearances.

UTAH

Bureau of Criminal Identification
3800 West 5400 South
P.O. Box 148280
Salt Lake City, UT 84114-8280
Phone: 801-965-4445 Fax: 801-965-4749
Fee: \$10.00, mo, cc, pc. Contact for release forms and finger print card.

WASHINGTON

Washington State Patrol
ID/Criminal History Section
P.O. Box 42633
Olympia, WA 98504-2633
Phone: 360-705-5100
Fee: \$25.00, pay to WA State Patrol, mo, cc.
Fingerprints required. Submit standard FBI card (FD-258). List ORI# WAWSP0000 on card. Reason fingerprinted: public information RCW 10.97.

WISCONSIN

Crime Information Bureau
Department of Justice
Attn: Record Check Unit
P.O. Box 2688
Madison, WI 53701-2688
Phone: 608-266-5764 TTY: 800-947-3529
Must request form DJLE-250
Fee: \$13.00, pay to WI Dept. of Justice, mo, cc.
Include SASE.

WYOMING

State of Wyoming
Office of the Attorney General
Division of Criminal Identification
316 West 22nd Street
Cheyenne, WY 82002
Phone: 307-777-7523 or 307-777-7181
Fee: \$15.00, mo, cc. Fingerprints required.
Contact for release forms and fingerprint cards.

TEXAS

DPS Crime Records Service
P.O. Box 15999
Austin, TX 78761-5999
Phone: 512-424-2079
Fee: \$15.00, pay to Texas Dept. of Public Safety, pc, mo. Fingerprints required.

VERMONT

Does not provide criminal history clearances.

VIRGINIA

Virginia State Police Records Management
Central Criminal Records Exchange
P.O. Box 85076
Richmond, VA 23261-5076
Phone: 804-323-2269
Fee: \$15.00, pay to Virginia State Police, mo, cc.

WEST VIRGINIA

West Virginia State Police
Records Div.– Criminal Identification Bureau
725 Jefferson Road
South Charleston, WV 25309-1698
Phone: 304-746-2180
Call first and request form 39A from Mr. Rodney Lambert.
Fee: \$20.00, mo, cc.

Appendix E: Legal References

It is expected that all providers will adhere to the applicable Federal, State, local statutes, laws, and/or administrative regulations, as applicable. The citations to law below are a **non-exclusive** list of the laws, statutes and/or administrative regulations that are applicable to the various levels of service and serve as **references only** by which the CBH manual was developed and written. It is the responsibility and burden of the provider to conduct their own legal research in order to know and implement the requirements of applicable laws and discipline-specific regulations as it pertains to the level of service. Most of this information is available through the Internet.

STATE:

28 Pa Code §704, (Staffing Requirements for Drug and Alcohol Treatment Activities).
28 Pa Code §709, Subchapter C (General Standards for Free-Standing Treatment Activities).
28 Pa Code §709, Subchapter I (Standards for Drug and Alcohol Outpatient Activities).
55 Pa Code §155 (Psychiatric Services).
55 Pa Code §157 (Drug and Alcohol Services – Inpatient Detoxification/Inpatient Hospital Activities).
55 Pa Code §1101. General Provisions (MA regulations and policies).
55 Pa Code §1153 (Outpatient Psychiatric Services).
55 Pa Code §1223 (Outpatient Drug and Alcohol Services).
55 PA Code §1247 (Targeted Case Management Services).
55 Pa Code §3800 (Child Residential and Day Treatment Facilities).
55 Pa Code §3810 (Residential Child Care Facility).
55 Pa Code §5100 (Mental Health Procedures – Inpatient and Outpatient).
55 Pa Code §5200 (Mental Health Procedures – Psychiatric Outpatient Clinics)
55 Pa Code §5210 (Mental Health Procedures – Partial Hospitalization).
55 Pa Code §5221 (Mental Health Procedures – Intensive Case Management).
50 P.S. §§4101-4704 (Mental Health and Mental Retardation Act of 1966).
50 P.S. §§7101-7503 (Mental Health Procedures Act).
71 P.S. §§1690.101-1609.115 (Pennsylvania Drug and Alcohol Abuse Control Act).
23 Pa C.S. §§6301 - 6385 (Child Protective Services Law).
35 P.S. §10225.101 (Older Adults Protective Services Act)
42 Pa C.S. §§6301-6365 (The Juvenile Act).
35 P.S. §780-101 (Pennsylvania Controlled Substance, Drug, Device and Cosmetic Act)
18 Pa. C.S.A. §101 (Pennsylvania Crimes Code)

Confidentiality:

28 Pa Code §709.28 (Regulation).
4 Pa Code §255.5 (Regulation - Disclosure of Consumer-Oriented Information).
55 Pa Code §§3490.91-3490.95 (Confidentiality).
55 Pa Code §§5100.31-5100.39 (Regulation – Confidentiality of Mental Health Records).
42 Pa Code §6352.1 (Act 126) (Regulation).
35 P.S. §§7601-7612 (Confidentiality of HIV-Related Information Act).
71 P.S. §1690.108 (Act 63) (State Law).
45 C.F.R. §160 (The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)).

FEDERAL:

Confidentiality:

42 C.F.R. Part II (Regulation).

42 U.S.C. §290ee-3 (drug law).

42 U.S.C. §290dd-3 (alcohol law).

OTHER AUTHORITIES:

Department of Health and Public Welfare, Medical Assistance Bulletin 99-00-05, November 28, 2000 (Consent Forms for the Release of Confidential Information).

Department of Health and Public Welfare, Medical Assistance Bulletin 29-02-03, 33-02-03, 41-02-02, March 21, 2002 (Documentation and Medical Record Keeping Requirements).

Department of Public Welfare, Mental Health and Substance Abuse Services Bulletin, OMHSAS-02-01, April 8, 2002 (The Use of Seclusion and Restraint in Mental Health Facilities and Programs).

Department of Public Welfare, Office of Mental Health and Substance Abuse Services, Guidelines for Best Practice in Child and Adolescent Mental Health Services, April 1999.

Philadelphia Behavioral Health System, Community Behavioral Health, Provider Bulletin #04-03, Comprehensive Biopsychosocial Re-Evaluation (CBR), February 28, 2003.

Philadelphia Behavioral Health System, Community Behavioral Health, Provider Bulletin #03-08, Revised Comprehensive Biopsychosocial Re-Evaluation (CBR), April 25, 2003.

Appendix F: Definitions

Act: The Mental Health Procedures Act (50 P.S. §§7101-7503).

Aftercare Plan: A plan for patients to follow after they leave formal treatment. It is the consumer's individual plan for the future, including identification of the consumer's personal goals and objectives (*Legal Reference:* 55 Pa Code §157.2).

CBH: Community Behavioral Health is a not-for-profit city-affiliated managed behavioral health care corporation established in the City of Philadelphia to administer the behavioral health component of the Commonwealth's HealthChoices program.

Child day treatment center: A premise or part thereof, operated for a portion of a 24-hour day in which alternative education, intervention or support programs are provided to one or more children to prevent the child's placement in a more restrictive setting or to facilitate a child's reunification with his family. A child day treatment center does not include: (*Legal Reference:* 55 Pa Code §3800.5)

- Mental health outpatient or partial hospitalization facilities
- Drug and alcohol outpatient facilities.
- Facilities that provide only aftercare services provided after regular hours.

Child Residential Facility: A premise or part thereof, operated in a 24-hour living setting in which care is provided to one or more children who are not relatives of the facility operator.

Clear and Convincing evidence: Evidence indicating that the event or thing to be proved is highly probable or reasonably certain; this is a greater burden than preponderance of the evidence, the standard applied in most civil cases, and less than evidence beyond a reasonable doubt, the norm for criminal trials.

Comprehensive evaluation: A comprehensive (**note:** "covering completely and broadly, inclusive") gathering of biopsychosocial information through consumer interview, discussion with family members and/or caretakers, review of clinical records, and contact with collaborating agencies that leads to biopsychosocial formulation, diagnoses, and a biopsychosocial treatment plan. (CBH)

Comprehensive medical history: A chronological medical record which includes, but is not limited to, major complaints, present and past medical history, family medical history and social (*Legal Reference:* 55 Pa Code §1101.21).

Detoxification: The process whereby a drug or alcohol intoxicated or dependant consumer is assisted through the period of time necessary to eliminate, by metabolic or other means, the presence of the intoxicating substance, while keeping the physiological or psychological risk to the consumer to a minimum. This process should also include efforts to motivate and support the patient to seek formal treatment after the detoxification phase (*Legal Reference:* 55 Pa Code §157.2).

Group Psychotherapy: Psychotherapy provided to no less than two (2) and no more than ten (10) persons with diagnosed drug/alcohol abuse or dependence problems for a minimum of one (1) hour. Drug/alcohol clinic psychotherapy personnel under the supervision of a physician shall conduct these sessions (*Legal Reference:* 55 Pa Code §1223.2)).

EPSDT: Early and Periodic Screening, Diagnosis and Treatment Program (*Legal Reference:* 55 Pa Code §1101.21). Please see Expanded Behavioral Health Services below.

Expanded Behavioral Health Services: behavioral health rehabilitation services (a/k/a, B.H.R.S.) for children under twenty-one (21) years of age to correct or improve a mental health illness or condition discovered by a screening. This is formerly known as E.P.S.D.T. or “wraparound” services.

Intensive Case Management: The services described in 55 Pa Code §5221 which are designed to assist targeted adults with serious and persistent mental illness and targeted children with a serious mental illness or emotional disorder and their families, to gain access to the needed resources, such as medical, social, educational and other services [*Legal Reference:* 55 Pa Code §5221.3]

Legal health Record (LHR): The legal business record generated at or for a healthcare organization. The LHR is the documentation of the healthcare services provided to an individual, used by the healthcare professionals while providing services, for reviewing consumer data, or documenting observations, action or instructions.

Methadone Maintenance: The provision of methadone to achieve stabilization or prevent withdrawal symptoms in persons dependent upon methadone or an opiate substance with an ultimate goal of permanent discontinued use of the methadone or opiate substance by the patient. Slow withdrawal or outpatient detoxification of the consumer from the maintenance substance is considered as a part of maintenance (*Legal Reference:* 55 Pa Code §1223.2).

Methadone Maintenance clinic visit: A minimum fifteen (15) minute visit only for administration of methadone, and evaluation of a consumer’s physical and mental condition during the course of prescribed methadone maintenance provided to an eligible recipient by a licensed physician or by drug/alcohol clinic medical personnel under the supervision of a physician in an approved drug/alcohol clinic (*Legal Reference:* 55 Pa Code §1223.2).

Medically Necessary – A service, item, procedure or level of care that is:

1. Compensable under the Medical Assistance Program.
2. Necessary to the proper treatment or management of an illness, injury or disability.
3. Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice (*Legal Reference:* 55 Pa Code §1101.21).

Older Adult: A person in the Commonwealth who is age sixty (60) or over. (*Legal Reference:* 35 P.S. §10225.103; *see* 71 P.S. §§581, 582)

Parent/Caretaker: The person responsible for the care and control of an unemancipated minor child. This includes mother or father, grandmother or grandfather, stepmother or stepfather or another relative related by blood or marriage (*Legal Reference:* 55 Pa Code §1101.21).

Preliminary evaluation: The initial assessment or evaluation of the physical and mental condition of an individual; it may be conducted without substantiation by formal testing procedures. The evaluation includes an assessment of the person’s specific physical, psychological, developmental, familial, educational or vocational, social, environmental needs in order to determine the adequacy, of the person’s logic, judgment, insight, and self control to responsibly meet his needs (*Legal Reference:* 55 Pa Code §5100.2).

Psychotherapy: The treatment, by psychological means, of the problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the consumer with the object of removing, modifying or retarding existing symptoms, mediating disturbed pattern of behavior and promoting positive personality growth and development (*Legal Reference:* 55 Pa Code §1223.2).

Targeted Case Management: Services which provide consumers with access to comprehensive medical and social services to encourage the cost effective use of medical and community resources, promoting the well-being of the consumer while ensuring the consumer's freedom of choice (*Legal Reference:* 55 Pa Code §1247.2).

Treatment Team: An interdisciplinary team of at least three (3) persons appointed by the facility director, composed of mental health professionals, health professionals and other persons who may be relevant to the consumer's treatment. The treatment team shall formulate and review an individualized treatment plan for every person who is in treatment under the Act.

Appendix G: CBH Auditing Tools

See next page.

Edited by: John A. O'Donnell, MS, JD

**PROVIDER NETWORK OPERATIONS
STAFF CREDENTIALING FILE REVIEW
COVERSHEET**

Site: _____

Reviewer's Name: _____

Employee's Name

Position

Date of Hire

1. _____

Comments: _____

Fire Safety Cultural Disaster Escalation Infection Suicide Seclusion/Restraint CPR

Employee's Name

Position

Date of Hire

2. _____

Comments: _____

Fire Safety Cultural Disaster Escalation Infection Suicide Seclusion/Restraint CPR

Employee's Name

Position

Date of Hire

3. _____

Comments: _____

Fire Safety Cultural Disaster Escalation Infection Suicide Seclusion/Restraint CPR

Employee's Name

Position

Date of Hire

4. _____

Comments: _____

Fire Safety Cultural Disaster Escalation Infection Suicide Seclusion/Restraint CPR

Employee's Name

Position

Date of Hire

5. _____

Comments: _____

Fire Safety Cultural Disaster Escalation Infection Suicide Seclusion/Restraint CPR

Employee's Name

Position

Date of Hire

6. _____

Comments: _____

Fire Safety Cultural Disaster Escalation Infection Suicide Seclusion/Restraint CPR

**PROVIDER NETWORK OPERATIONS
CLINICAL AUDIT SCORESHEET
STAFF CREDENTIAL TALLY**

Facility:	Reviewer:	Date:	Total Percentage:												
Staff Category															
Staff Initials															
		1	2	3	4	5	6	7	8	9	10	11	12	TOTAL	
Credentialing Application	2														
Child Abuse Clearance	2														
Criminal History Clearance	2														
Academic Degree Confirmation	2														
Job Descriptions	2														
Job Qualifications ("0" or "2" only)	2														
Resume/CV/Application	2														
Employment Verific/Performance Eval	2														
Mandatory In-service Training	2														
Ongoing In-service Training	2														
License(s)/Certification(s)	2														
National Pract'nr Data Bank (MD only)	2														
Prof. Liability Insurance (MD only)	2														
DEA Certification (MD only)	2														
Total Raw Score	28	/	/	/	/	/	/	/	/	/	/	/	/	/	

STAFF KEY

MD	Medical Director	MHN	Mental Health/Addictions Nurse
PD	Program Director/Project Director	CM	Case Manager
ED	Executive Director	CS	Mental Health Clinical Supervisor
Psychi	Psychiatrist	BSC	Behavioral Specialist Consultant
Psycho	Clinical Psychologist	MT	Mobile Therapist
SW	Social Worker	TSS	Therapeutic Support Staff
MHW	Mental Health Worker	TSSA	Therapeutic Support Staff Aide
MHP	Mental Health Professional	TCMS	Targeted Case Manager Supervisor
SAA	Substance Abuse Assessor	TCM	Targeted Case Manager
SAC	Substance Abuse Counselor		
SACA	Substance Abuse Counselor		
SACS	Substance Abuse Clinical		

Category:

1. 60% or below.
2. 61% - 80%
3. 82% - 100%

**PROVIDER NETWORK OPERATIONS
CLINICAL SITE REVIEW
COVERSHEET**

Site: _____ Modality: _____ Reviewer: _____ Date: _____

Program Location: _____.

	<u>Patient Name</u>	<u>Soc. Sec. #</u>	<u>DOB</u>	<u>Admission Date</u>
1.	_____	_____	_____	_____

Comments: _____

	<u>Patient Name</u>	<u>Soc. Sec. #</u>	<u>DOB</u>	<u>Admission Date</u>
2.	_____	_____	_____	_____

Comments: _____

	<u>Patient Name</u>	<u>Soc. Sec. #</u>	<u>DOB</u>	<u>Admission Date</u>
3.	_____	_____	_____	_____

Comments: _____

	<u>Patient Name</u>	<u>Soc. Sec. #</u>	<u>DOB</u>	<u>Admission Date</u>
4.	_____	_____	_____	_____

Comments: _____

	<u>Patient Name</u>	<u>Soc. Sec. #</u>	<u>DOB</u>	<u>Admission Date</u>
5.	_____	_____	_____	_____

Comments: _____

CLINICAL AUDIT FORM: ASSESSMENT & EVALUATION

	Value	1	2	3	4	5	Total Pts	% Score
"Biopsychosocial" Assessment	Points						240	
Behaviorally defined presenting problem(s)	2							
Comprehensive medical history	2							
Consumer allergies noted (food, drug, environmental)	2							
Comprehensive psychiatric history	2							
Comprehensive substance abuse history	2							
Past Medication history.	2							
Present Medication status.	2							
Comprehensive educational history	2							
Comprehensive maturational history (<i>children/MR only</i>)	2							
Comprehensive spiritual history.	2							
Comprehensive nutritional history.	2							
Comprehensive vocational/occupational history.	2							
Comprehensive legal history	2							
Comprehensive sexual history	2							
Past/Present History of Aggression/Suicidality/Abuse	2							
Social elements in consumer's life	2							
Consumer's support system	2							
DSM IV five (5) axes diagnosis	2							
Consumer goals for treatment	2							
Strengths & barriers to treatment.	2							
Mental status exam	2							
Biopsychosocial is legible.	2							
Evidence of initial discharge planning is present.	2							
Assessment completed w/i policy timeframe?	2							
SCORE	48	/	/	/	/	/	/	0%

**PROVIDER NETWORK OPERATIONS
CLINICAL AUDIT FORM: TREATMENT PLANNING**

	Value	1	2	3	4	5	Total Pts	% Score
Treatment Plans	Points						210	
Date of admission.	2							
Date of initial treatment plan	2							
Date of present treatment plan	2							
Date of subsequent treatment plan	2							
DSM-IV five (5) axes diagnosis	2							
Behaviorally defined problem statement	2							
Measurable treatment goals.	2							
Interdisciplinary treatment approach	2							
Consumer involvement in formulation of TX plan	2							
Methods of treatment are noted	2							
Interventions are specified.	2							
Staff responsibility for interventions.	2							
Consumer strengths & barriers	2							
Statement of understanding is present on treatment plan	2							
TX plans are signed by all treatment team members	2							
Statement of progress on updated TX plans.	2							
Treatment plans are legible?	2							
Treatment plans are completed within policy timeframe	2							
For Children's services : Educational plan reflected.	2							
Nursing care plan identifying physical problem	2							
Nursing and Medical interventions denoted	2							
SCORE	42	/	/	/	/	/	/	0%

**PROVIDER NETWORK OPERATIONS
CLINICAL AUDIT FORM: DISCHARGE DOCUMENTATION**

	Value	1	2	3	4	5	Total Pts	% Score
Discharge Planning	Points						190	
Discharge Note includes:								
Consumer's behavior/attitude upon discharge	2							
Consumer's destination/mode of transportation (IP only)	2							
Treatment outcomes	2							
Consumer is informed/aware of follow-up appts	2							
Aftercare Planning includes:								
All critical problems of consumer	2							
Signature of consumer is present	2							
Follow-up appts. appear on aftercare plan	2							
Consumer's living arrangements noted (<i>inpatient only</i>).	2							
Consumer's method of obtaining medications is noted	2							
Crisis plan for consumer is documented.	2							
Discharge summary includes:								
Reasons for treatment are documented.	2							
Service(s) offered are documented.	2							
Initial & Final DSM IV-R five (5) axes diagnosis	2							
Consumer progress (or lack thereof) is documented.	2							
Discharge medications are listed (<i>if applicable</i>)	2							
Recommendations for aftercare	2							
Special needs of consumer are identified	2							
Medical/Psychosocial problems are noted	2							
Consumer status/condition upon discharge documented								
Anticipated problems/concerns for future compliance	2							
Primary Care Physician is identified (<i>if known</i>)	2							
Clinical Director/Psychiatrist co-sign discharge?	2							
Transfer summary includes:								
Signed Physician order is present for transfer	2							
Evidence that consumer was informed of transfer.	2							
Documentation of consumer condition upon transfer.	2							
Consumer response to transfer is recorded.	2							
Transfer medication information is documented.	2							
Consumer Family/support network notified of transfer	2							
Comprehensive transfer note present (see manual)	2							
SCORE	56	/	/	/	/	/	/	0%

**PROVIDER NETWORK OPERATIONS
ADMINISTRATIVE SITE REVIEW
OUTPATIENT/INPATIENT/PARTIAL POLICIES & FORMS**

Facility		Date		Reviewer	

CREDENTIALING REVIEW <input type="checkbox"/>	RE-CREDENTIALING REVIEW <input type="checkbox"/>
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CRITERIA	TOTAL POINTS	Comments	CREDENTIALING POINTS	Comments	RE-CREDENTIALING POINTS
Admissions/Intake policy	2				
Appointments/Rescheduling policy (O.P. only)	2				
Assessment & Evaluation policy	2				
Clinical Supervision policy	2				
Comprehensive Biopsychosocial Eval. Policy	2				
Confidentiality policy	2				
Consumer Rights policy	2				
Continued Stay/Concurrent Review policy	2				
Criminal History/Child Abuse Clearance policy	2				
Demographic Information policy	2				
AFA/AMA/Administrative Discharge policy	2				
Discharge/Aftercare policy	2				
Employee Orientation policy	2				
Employee Sanctions policy	2				
Incident /Occurrence policy	2				
Individual Service Plan Development policy	2				
Informed Consent policy	2				
In-service Training (Mandatory/Ongoing) policy	2				
Management of Escalation policy	2				
Medical Information policy	2				
Medication Management policy	2				
On-Call Emergency Protocol policy (O.P. only)	2				
Physical Plant policy	2				
Progress/Session Notes policy	2				
Psychiatric/psychological evaluation policy	2				
Quality Assurance policy	2				
Referral System policy	2				
Release of Information policy	2				
Restrictive Procedures policy (Adult/Children)	2				
Suicide Assessment policy	2				
Treatment Plan policy (Initial/Updated)	2				
TOTAL POSSIBLE SCORE	62				

CATEGORY: 1 2 3 (circle one)	31 policies total
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CATEGORY:

- 1. 60% or below
- 2. 61% - 80%
- 3. 81% - 100%
- N/A = not applicable

**PROVIDER NETWORK OPERATIONS
ADMINISTRATIVE SITE REVIEW
INDEPENDENT PRACTITIONERS**

Facility		Date		Reviewer	

CREDENTIALING REVIEW <input type="checkbox"/>	RE-CREDENTIALING REVIEW <input type="checkbox"/>
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CRITERIA	TOTAL POINTS	Comments	CREDENTIALING POINTS	Comments	RE-CREDENTIALING POINTS
Compliance policy	2				
Confidentiality policy	2				
Employee Sanctions policy	2				
Maintenance of Clinical Records policy	2				
Quality Assurance policy	2				
TOTAL POSSIBLE SCORE	10				

CATEGORY: 3 YES NO