ACR Health Services Policy and Procedures Manual

Assertive Community Recovery, LLC
d/b/a ACR Health Services

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ACR Policy and Procedure Manual Table of Contents

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Policy 01.01 - Mission and Values

Mission Statement

The purpose of Assertive Community Recovery, LLC (ACR) is to ensure that individuals with mental health and substance abuse needs receive the most appropriate and effective treatment in the least restrictive and most cost-efficient setting. ACR is not only committed to helping people live in the community, but also to help people live with the community. To that end, all treatment shall be focused around the principles of recovery, resilience and self-determination.

Values Statement

ACR is organized around core principle of delivering high quality treatment services in a way that is fully accessible and person centered. Pursuit of this principle is guided by a commitment to the provision of treatment that is comprehensive, community based, and delivered in the least restrictive setting with a focus on allowing individuals and their family to have their preferences known and to direct the delivery of treatment.

To fulfill these values, ACR adheres to and believes in the following guiding principles:

1. Family integrity is of paramount importance. Needs for security, permanency and cultural ties in family relationships should pervade all planning. Families should participate fully in all decisions concerning planning, placement, program and discharge.
2. ACR shall work with other social service agencies within its service area to achieve the best possible outcome for individuals.
3. Individuals shall participate fully in all service planning decisions. The uniqueness and dignity of the individual shall govern service decisions. Individualized Recovery Plans shall reflect the individual's developmental needs that include family, emotional, intellectual, physical, social and cultural factors.
4. Culturally competent services will be guided by the concept of equal, responsive and nondiscriminatory services matched to the individual population. Cultural competence involves working with natural, informal support and helping networks within minority communities. Inherent in cross-cultural interactions are dynamics that must be acknowledged, accepted and adopted.
5. Cultural competence extends the concept of self-determination to the community.
6. ACR recognizes that minority populations are at least bicultural and that this status creates a unique set of mental health and substance abuse issues to which the system must be equipped to respond. Thus the system must sanction and, in some cases, mandate the incorporation of cultural knowledge into practice and policy-making.
7. Individuals who have mental illnesses and/or substance abuse problems shall be treated with dignity and respect, as they have the same needs, rights and responsibilities as other citizens. Thus these individuals should have the same access to opportunities, supports and services to help them live successfully in the community.

8. ACR services shall help individuals to empower themselves, focus on strengths, maintain a sense of identity and enhance self-esteem. Services should help people develop their potential for growth and movement towards independence.
9. ACR services shall meet the special needs of people with mental illness and/or substance abuse problems who are also affected by one or more of such factors as: old age, physical disability, homelessness, the AIDS virus and/or involvement in the criminal justice system.
10. ACR services shall be coordinated through mandated linkages with individuals/families, both at the local and state levels. Continuity of care for people discharged from hospitals to community-based services shall be ensured.
11. ACR shall be accountable to the program participants, who should help plan, implement, monitor and evaluate the services they receive.

Policy 01.02 - Letter to Employees
Corporate Compliance

Dear Colleague,

Assertive Community Recovery, LLC (ACR) is committed to providing quality care to our consumers. Within this commitment, we strive to ensure that the highest ethical standards are evident in our delivery of behavioral healthcare. We must demonstrate as individuals and as an organization that all our actions are founded on the principles of accountability and integrity.

Our organization recently completed a resolution establishing a Compliance Program within our organization. ACR's development and integration of a Compliance Program will provide guidance to ensure that our services are provided in an ethical and legal manner. The program emphasizes the shared common values that guide our behaviors and contains resources to assist in resolving questions about appropriate conduct in the work place.

ACR has appointed Trese Harris as our Compliance Officer to ensure that the program is fully operational and meets the intended goal of organizational accountability and integrity. As an employee of ACR, you will be provided with a variety of training and education to assist in your full participation in the program. As will become evident as the program is integrated into our daily culture, you will be an important component through assisting with the monitoring of compliance within the organization.

If you have any questions regarding this program or encounter any situation that you believe violates the provisions of the program, please consult with your supervisor, contact Trese Harris, Compliance Officer at 404-508-0078, or you may make anonymous reports online through www.AccrediationNow.com, Compliance Reporting System. I assure you that there will be no retribution for asking questions or raising concerns about the program, or for reporting possible improper conduct.

In addition, you may anonymously make reports directly to:

Georgia Department of Behavioral Health & Developmental Disabilities
Two Peachtree Street, N.W.
24th Floor
Atlanta, Georgia 30303
404-657-2252

or

Region 3 Office of DBHDD at Georgia Regional Hospital-Atlanta
3073 Panthersville Rd,
Building 10, Decatur, GA 30034
404-244-5068
Phone: (770) 414-3052
Fax: (770) 414-3048

or

Office of Inspector General Fraud Hotline
OIG Hotline: 1-877-423-4746
OIG Fax: 404-463-5496
OIG Email: inspectorgeneralhotline@dhr.state.ga.us
Via the Web: online form: https://dhs.georgia.gov/dhs-oig-incident-form

We are committed to the ideals reflected in our Mission and Core Values and in the Compliance Program. We are equally committed to assuring that our actions reflect our words. We trust you as a valuable member of our behavioral healthcare team, and ask you to assist our organization in supporting the Compliance Program and the values and principles critical to achieving our mission.

Policy 01.03 – Compliance Resolution

WHEREAS, the Ownership desires to affirm its commitment to ensure that Assertive Community Recovery, LLC (ACR) d/b/a ACR Health Services operates its business in full compliance with the laws and regulations of the United States and the state of Georgia; and

WHEREAS, it is in the best interest of the organization to demonstrate ethical, legal, and solvent business practices by adopting and supporting a formal compliance program to prevent, detect, investigate, and correct instances of noncompliance, whether intentional or unintentional; and

WHEREAS, the position of a Corporate Compliance Officer has been created and given authority to develop and implement an effective compliance program for Assertive Community Recovery, LLC (ACR) d/b/a ACR Health Services; and

WHEREAS, the Corporate Compliance Officer is authorized to provide regular reports to the Chief Executive Officer that detail assurances of appropriate practices and ongoing compliance activities and issues; and

THEREFORE, BE IT RESOLVED, that the Ownership of Assertive Community Recovery, LLC (ACR) d/b/a ACR Health Services do hereby support the development of a corporate compliance plan and program for the organization and assign the responsibility for the implementation of the plan to the Corporate Compliance Officer with the support and assistance of the management of Assertive Community Recovery, LLC (ACR) d/b/a ACR Health Services.

Policy 01.04 - Management Structure

I. POLICY:

It is the policy of ACR to make best use of the expertise of agency personnel by involving them in an open management system of committees and meetings that formalizes and structures their participation in the running of the agency's activities. As part of a system of internal controls. ACR will

II. PROCEDURES:

A. As part of a system of internal controls. ACR will define the structure of the Leadership and Management structures of the agency and identify the roles and responsibilities of each level of leadership.

B. There will normally be monthly meetings of a Leadership Team comprised of the Executive Director, Clinical Director, the Program Managers/Team Leaders, the Human Resources Director, the Corporate Compliance Officer, and such other staff as may be chosen by the Team.

C. The primary tasks of the Leadership Team are to receive regular reports from Program Managers and other agency employees, to assist the Executive Director discharge his or her management responsibilities, to engage in long-term strategic planning, and to generate proposals for improvements to ACR mission and functions.

D. The Leadership Team is responsible for assisting the Executive Director in:

1. The implementation of the agency's Mission (Policy 1.01)
2. The promotion of value / achievement of outcomes in the programs and services offered.
3. Balancing the expectations of both persons served and other stakeholders.
4. Maintaining the financial solvency of the agency.
5. Complying with insurance and risk management requirements.
6. Ongoing performance improvement
7. Development and implementation of corporate responsibilities
8. Compliance with all applicable legal and regulatory requirements

E. Minutes will be taken at all meetings of Leadership Team and at Managers' meetings, and a permanent archive of these minutes will be maintained in the Quality Assurance Office.

F. The Leadership Team shall review reports covering the following (see also Policy 15.01):

1. Quality Improvement Program (QIP) (Outcomes management in relation to the quality, appropriateness, effectiveness and efficiency of service delivery)
2. Consumer Rights (Investigation of consumer complaints and other matters regarding consumer rights)
3. Peer Review (Investigation and review of care and treatment provided to consumers, professional evaluation of care providers)
4. Physicians (Medical practice and medication procedures).
5. Safety (examination of safety issues, investigation of incidents, coordination of site safety inspections and safety drills)
6. Cultural Diversity (promoting policies and practices to develop equality of opportunity, accessibility of services, and cultural competency within the agency and its staffs)

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Policy 01.05 - Organizational Fundraising

It is the policy of Assertive Community Recovery, LLC d/b/a ACR Health Services that **ACR does not accept donations, participate in or conduct any fundraising activities** of any kind to support its programs, the services that we provide to individuals or to support our business operations.

Policy 02.01 - Equal Employment Opportunity (EEO)

I. POLICY:

Assertive Community Recovery, LLC is an equal opportunity employer. ACR provides employment opportunities to applicants on the basis of job related qualifications. All employment related decisions are made without regard to race, sex, age, color, religion, national origin, political affiliation, or disability. This policy applies to recruitment, hiring, promotions, compensation, benefits, transfers, layoffs, in-service training, staff development, discipline grievance handling and/ or Employee Relations Management.

ACR's designated EEO Officer is the Director of Quality Assurance/Compliance. The position's incumbent is responsible for assuring compliance with agency requirements for non-discrimination and adherence to the agency's Equal Opportunity Employment.

This policy is applicable to those persons in all classes protected from discrimination by, and is designed to be in accordance with, the provisions of Title VII of the Civil Rights Act of 1964, '503 and '504 of the Vocational Rehabilitation Act of 1973, the Age Discrimination and Employment Act (1967), the Americans with Disabilities Act (1990), the Family Medical Leave Act of 1993, regulations issued by the U. S. Department of Health and Human Services, and other applicable legislation and regulations.

It is the policy of ACR to promote and encourage the employment of members of various cultures and ethnicity that mirrors ACR's client population.

The intent of ACR's equal employment opportunity policy is to be nondiscriminatory and to ensure employment practices are carried out in accordance with EEO mandates.

ACR subscribes to the following principles governing EEO:

1. Continued efforts are made to attract applicants from all population groups. All applicants and employees are treated equally and fairly.

2. Required qualifications for a job reflect realistic requirements. Unreasonable and superfluous levels of education, experience, and demonstrated competence that does not relate to job requirements will not be required of an applicant. Employment selection is based on job-related knowledge, skills, and abilities, and reflects essential functions of the position.

3. Human resources and recruitment/ selection records are maintained to advance the EEO policies and to document conformance.

4. Equal pay is offered for equal work.

5. Employees are selected for promotion on the basis of their position related qualifications.

6. Transfer of employees, when necessary, is based on program needs and position related qualifications.

7. Non-discriminatory practices are adhered to in the resolution of employee grievances. The filing of a grievance will in no way impact on the employee's treatment while performing job duties and responsibilities.

II. Responsibility

The Executive Director, as Chief Human Resources Officer is ultimately responsible for execution of policy related to EEO. The Director of Quality Assurance/Compliance is ACR's designated EEO Officer and has responsibility for making certain the policy is fully understood, that effective programs are implemented and that appropriate support is provided through the Human Resources Office to line management to assist them in adherence to EEO. The designated EEO Officer is also responsible for coordinating the day-to-day implementation of our EEO plans and for the regular reporting of progress and deficiencies to the CEO/Executive Director.

III. Procedures

Any employee or applicant for employment who feels their EEO rights are being violated should immediately contact the Executive Director or The Director of Quality Assurance/Compliance. All complaints will be immediately and thoroughly investigated. Penalties for founded cases of EEO violations will be determined and may include immediate discharge of an employee in violation of EEO laws and guidelines.

Policy 02.02 - Code of Conduct

I. POLICY:

It is the policy of Assertive Community Recovery that all full and part-time employees, contractors, students, volunteers (collectively referred to as "staff"), and members of the governing authority are to have an obligation to perform their designated functions in a manner that reflects the highest standards of ethical behavior. The ethical standards contained in this policy shape the culture and norms of ACR administrative operations and clinical practices, and both staff and members of the governing authority will be held fully accountable to these standards. In addition to the specific guidelines contained in the policy, professionals are expected to follow the ethical standards required by their specific licensing and certification boards. The Code of Conduct Policy is to ensure that all employees' actions reflect a competent, respectful, and professional approach when serving individuals, their families and/or representatives, working with other providers of services, and interacting within the communities we serve. It is expected that staff and members of the governing authority will perform their duties in compliance with all federal, state, and local regulations in accordance with guidelines set forth in this policy.

Employment with ACR is at the mutual consent of ACR and the employee, and either party may terminate that relationship at any time, with or without cause, and with or without advance notice. Violation of guidelines within the Code of Conduct Policy can lead to disciplinary actions, including termination.

II. PROCEDURES:

A. Professional Conduct:

1) ACR staff will respect the rights of individuals by demonstrating full integration of the guidelines contained in the Rights and Responsibility Policy. This includes the right of the individual to make autonomous decisions and fully participate in every aspect of the service delivery process.

2) ACR staff will provide services in a manner that fully respects the confidentiality of individuals, by demonstrating a functional knowledge of confidentiality policies and guidelines.

3) ACR staff will be fair and honest in their work. They will not exploit or mislead, and will be faithful to their contractual obligations and their word.

4) To prevent and avoid unethical conduct, ACR employees will consult with, refer to, and cooperate with other professionals. ACR employees will clarify their professional roles and obligations and be accountable for upholding professional standards of practice.

B. Personal/Professional Conduct:

1) All prior personal relationships between staff and persons entering the organization's programs shall be disclosed by the staff member and subject to review by the appropriate supervisor.

2) Staff will limit relationships with persons served to their defined professional roles.

3) Staff will not establish ongoing personal or business relationships with individuals receiving services.

4) Staff will conduct themselves in a professional, ethical, and moral manner.

5) Sexual relationships between staff and person's served are never appropriate. Sexual relationships include, but are not limited to the following: engaging in any type of sexual activity, flirting, advances and/or propositions of a sexual nature, comments of a sexual nature about an individual's body, clothing, or lewd sexually suggestive comments.

6) Staff will not accept gifts of value from a individual, family member, or stakeholder, and cannot accept personal favors or benefits that may reasonably be construed as influencing their conduct.

7) ACR Certified Peer Specialists (CPS) have an important role in the encouraging and supporting the recovery of individuals served. In assisting individuals served, CPS will use many engagement techniques to encourage individuals to participate in recovery services to include sharing their life story in such detail that staff members who are not CPS should reframe from doing. However, in fulfilling their professional responsibilities CPS shall always promote the recovery individuals by encouraging individuals to move toward independence and resiliency without the support of paid staff. As a member of ACR's treatment team, CPS will adhere to all sections of this standard and ensure that all contacts with individual served are limited to their professional role. In that regard the contacts that a CPS can make with an individual served shall be limited to those activities as outlined in most recent DBHDD Providers Manual.

C. Business Practices:

1) ACR will utilize the Corporate Compliance Officer to ensure that it conducts business in an ethical manner and ensure that any business practices that are questionable are thoroughly investigated the ethical investigation procedures that follow in this policy.

2) All financial, purchasing, personnel, facility development and information technology practices shall comply with local, state, and federal law and guidelines.

3) All staff members shall adhere to ACR's Human Resource Policies and Procedures.

D. Marketing Practices:

1) ACR will conduct marketing practices in an honest and factual manner. Marketing materials and practices will in no way mislead the public or misrepresent ACR's

abilities to provide services. ACR will not claim any service outcomes unless represented by valid and reliable outcome data and/or research studies.

2) ACR will utilize clear and consistent methods of communicating information to individuals, family members, third-party entities, referral sources, funding sources, and community members, and will exhibit sensitivity to the educational and reading levels of all persons when distributing information.

3) ACR will not utilize monetary rewards or gifts to any potential individual of services in an attempt to entice them to enter programs.

E. Clinical Practices:

1) Staff will adhere to all professional codes of conduct and ethical standards for his/her specified professional discipline.

2) As part of new employee orientation, staff will read the organization's Code of Conduct and demonstrate knowledge of the guidelines.

F. Potential Conflicts of Interest:

1) No individual will be hired or placed in an employee/employer relationship with ACR while an active participant in programming.

2) Any programming that involves a work task, and remuneration for the task, will be therapeutic in nature and will be documented as such by programming guidelines based on theoretical constructs.

3) ACR staff will not engage in outside professional mental health services that are incompatible or in conflict with job duties within the organization.

4) Private practice must be done on the staff's own time and outside the organization, as long as such activities are not adverse to the interests and goals of ACR and have met the organization's guidelines on conducting a private practice.

5) Staff will not recruit clients for their private practice within their professional roles as ACR staff members.

6) If an staff member leaves ACR and enters private practice, the individual may choose to continue their therapy with the former employee. However, the therapy must be offered at the same cost with equal accessibility to therapy.

7) No staff shall engage in any other employment or activity on the organization's premises or to an extent that affects, or is likely to affect, his or her usefulness as an employee of the organization.

G. Quality of Care:

1) ACR will provide quality behavioral health care in a manner that is appropriate, determined to be necessary, efficient, and effective.

2) Health care professionals will follow current ethical standards regarding communication with individuals and their representatives regarding services provided.

3) ACR will inform individuals about alternatives and risks associated with the care they are seeking and obtain informed consent prior to any clinical interventions.

4) ACR recognize the right of individuals to make choices about their own care, including the right to do without recommended care or to refuse care.

H. Necessity of Care:

1) ACR shall submit claims for payment to governmental, private, or individual payers for those services or items that are clinically necessary and appropriate.

2) When providing services, ACR employees shall only provide those services that are consistent with generally accepted standards for treatment and are determined by the professional to be clinically necessary and appropriate.

3) Service providers may determine that services are clinically necessary or appropriate; however, the individuals funding source may not cover or approve those services. In such a case, the individual may request the submission of a claim for the services to protect his/her rights with respect to those services or to determine the extent of coverage provided by the payer.

4) Coding and documentation will be consistent with the standards and practices defined by the organization in its policy, procedures, and guidelines.

I. Coding, Billing, and Accounting:

1) ACR staff involved in coding, billing, documentation and accounting for individual care services for the purpose of governmental, private or individual payers will comply with all applicable state and federal regulations and organizational policies and procedures.

2) ACR will only bill for services rendered and shall seek the amount to which it is entitled.

3) Supporting clinical documentation will be prepared for all services rendered. If the appropriate and required documentation has not been provided, then the service has not been rendered.

4) All services must be accurately and completely coded and submitted to the appropriate payer in accordance with applicable regulations, laws, contracts, and organizational policies and procedures. Federal and state regulations take precedence, and organizational policies and procedures must reflect those regulations.

5) Individuals shall be consistently and uniformly charged.

6) Government payers shall not be charged in excess of the provider's usual charges.

7) Billing and collections will be recorded in the appropriated accounts.

8) An accurate and timely billing structure and medical records system will ensure that ACR effectively implements and complies with required policies and procedures.

J. Cost Reports:

1) ACR will ensure that all preparation and cost reports submitted to governmental and private organizations are properly prepared and documented according to all applicable federal and state laws.

2) All cost reports will be submitted and prepared with all costs properly classified, allocated to the correct cost centers, and supported by verifiable and auditable cost data.

3) All cost report preparation or submission errors and mistakes will be corrected in a timely manner and, if necessary, clarify procedures and educate employees to prevent or minimize recurrence of those errors.

K. <u>Personal and Confidential Information:</u>

1) ACR will protect personal and confidential information concerning the organization's system, employees, and individuals.

2) ACR personnel shall not disclose confidential individual information unless at the individual's request and/or when authorized by law. Appropriate use of individual information for research purposes must be obtained with the full informed consent of participants in the research.

3) Confidential information will only be discussed with or disclosed to persons and entities outside the organization through the request of the individual. Persons outside the organization include the family, business, or social acquaintances of the individual.

4) Individuals can request, and are entitled to receive copies or summaries of their records with the exception of minors and individuals being treated for alcohol and drug abuse, who may be provided with copies of their record if it is judged appropriate by the provider charged with their care.

5) ACR personnel will be familiar with all organizational policy and procedures regarding confidentiality.

L. <u>Creation and Retention or Individual and Institutional Records:</u>

1) Records are the property of the organization. Personnel responsible for the preparation and retention of records shall ensure that those records are accurately prepared and maintained in a manner and location as prescribed by law and organizational policy.

2) Staff will not knowingly create records that contain any false, fraudulent, fictitious, deceptive, or misleading information.

3) Staff will not delete any entry from a record. Records can be amended and material added to ensure the accuracy of a record in accordance with policy and procedures. If a record is amended, it must indicate that the notation is an addition or correction and record the actual date that the additional entry was made.

4) Staff will not sign someone else's signature or initials on a record.

5) Records shall be maintained according to specific organizational policy and procedure.

6) Staff shall not destroy or remove any record from the organization's premises.

7) The organization will maintain record retention and record destruction policies and procedures consistent with federal and state requirements regarding the appropriate time periods for maintenance and location of records. Premature destruction of records could be misinterpreted as an effort to destroy evidence or hide information.

M. Government Investigation:

1) ACR staff members shall cooperate fully with appropriately authorized governmental investigations and audits.

2) ACR will respond in an orderly fashion to the government's request for information through employee interviews and documentation review.

3) The organization will respond to the government's request for information in a manner that enables the organization to protect both the organization and individual's interests, while cooperating fully with the investigation.

4) When a representative from a federal or state agency contacts an ACR staff member at home or at their office for information regarding the organization or any other entity with which the organization does business, the individual will contact the CEO immediately.

5) ACR staff will ask to see the government representative's identification and business card, if the government representative presents in person. Otherwise, the staff member should ask for the person's name, office, address, phone number, and identification number and then contact the person's office to confirm his/her identity.

N. Prevention of Improper Referrals or Payments:

1) ACR staff will not accept, for themselves or for the organization, anything of value in exchange for referrals of business or the referral of individuals.

2) Staff must not offer or receive any item or service of value as an inducement for the referral of business or individuals.

3) Federal law prohibits anyone from offering anything of value to a Medicare or Medicaid individual that is likely to influence that person's decision to select or receive care from a particular behavioral health care provider.

4) The organization shall establish procedures for the review of all pricing and discounting decisions to ensure that appropriate factors have been considered and that the basis for such arrangements is documented.

5) Development or initiation of joint ventures, partnerships, and corporations within the organization must be reviewed and approved by the organization's management to ensure compliance with organizational policy and federal regulations.

O. Antitrust Regulations:

1) ACR will comply with all applicable federal and state antitrust laws.
2) Staff should not agree or attempt to agree with a competitor to artificially set prices or salaries, divide markets, restrict output, or block new competitors from the market, share pricing information that is not normally available to the public, deny staff privileges to qualified practitioners, or agree to or participate with competitors in boycott of government programs, insurance companies, or particular drugs or products.

P. Avoiding Conflicts of Interest:

1) All ACR staff shall conduct clinical and personal business in a manner that avoids potential or actual conflicts of interests.
2) Staff shall not use their official positions to influence an organizational decision in which they know, or have reason to know, that they have a financial interest.
3) Staff must be knowledgeable about activities that may be an actual or potential conflict of interest. Examples of such activities may include, but are not limited to the following:
    a. Giving or receiving gifts, gratuities, loans, or other special treatment of value from third parties doing business with or wishing to do business with the organization. Third parties may include, but are not limited to, individuals, vendors, suppliers, competitors, payers, carriers, and fiscal intermediaries.
    b. Using ACR's facilities or resources for other that organization sanctioned activities.
    c. Using ACR's name to promote or sell products or personal services.
    d. Contracting for goods or services with family members of the organization directly involved in the purchasing decision.

Q. External Relations:

1) ACR staff shall adhere to fair business practices and accurately and honestly represent themselves and the organization's services.
2) ACR staff will be honest and truthful in all marketing and advertising practices pertaining to the business practices of the organizations service delivery system.
3) Vendors who contract to provide goods and services to the organization will be selected on the basis of quality, cost-effectiveness and appropriateness for the identified task or need, in accordance with organization policy.

R. Treatment of Employees:

1) ACR prohibits discrimination in any work-related decision on the basis of race, color, national origin, religion, sex, physical or mental disability, ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran. The organization is committed to providing equal employment opportunity in a work environment where each employee is treated with fairness, dignity, and respect.

2) ACR will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities.
3) ACR does not tolerate harassment or discrimination by anyone based on the diverse characteristics or cultural backgrounds of those who work for the organization pursuant to the organization's affirmative action policy.
4) Any form of sexual harassment is prohibited.
5) Any form of workplace violence is prohibited.

S. Code of Conduct Procedures:

1) All employees, students, volunteers and governing authority members, as part of the organization's initial orientation, will review the Code of Conduct, including the procedures for investigating and acting on conduct violations.
2) All staff will receive a copy of the Code of Conduct, sign a form acknowledging their review and full understanding of the code, and return the form to be filed in the employee's personnel file.
3) To assure an awareness of ethical practices, reviews of the Code of Conduct and continued training will be conducted on an annual basis.

T. Procedures for Investigating and Acting on Violations of the Code of Conduct:

1) When any individual, family member, authorized representative, advocate or other person believes that an ethical violation has occurred within the operations of the organization, they may report such suspicion directly to any employee, or management staff.
2) When employees believe a violation of the Code of Conduct has occurred they are obligated to report the violation in one of the following ways:
    a. Immediate notification of the incident or violation through the organization's corporate compliance program and reporting mechanisms.
    b. Immediate reporting to their supervisor or to corporate compliance officer if the suspected violation involves their supervisor.
3) Supervisors who have been informed of a suspected violation are required to immediately inform the corporate compliance officer of the suspected violation.
4) If the violation involves a direct and immediate threat to the safety of a patient, staff member, or clinic visitor, employees are obligated to report the alleged violation immediately to their supervisor.
5) Staff is required to report any suspected violation of the Code of Conduct; however, they are not required to investigate or know for certain that a violation has occurred.
6) Once the questionable behavior has been brought to the attention of the supervisor or reported through the corporate compliance procedures, staff reporting the

situation will no longer have a responsibility for being involved with the investigation other than providing additional information through a requested interview by the investigator.

7) Staff must report each suspected violation of the Code of Conduct separately, should a violation that has been reported occur again.

8) When any suspected violation of the Code of Conduct is reported to a supervisor, program sponsor or the corporate compliance officer, the corporate compliance officer will begin an investigation of the matter immediately. While investigating the complaint, the following issues should be considered and action taken depending on the situation:

    a. Is any client in any harm or potential harm because of this behavior?

    b. Does the complaint require immediate action to remove the employee from contact with a client?

    c. Does the complaint put ACR or its employee in a potentially liable situation that needs legal consultation?

9) Code of Conduct investigations will follow the guidelines outlined in the ACR's Corporate Compliance Policy and Procedure.

U. <u>General Ethical Guidelines and Considerations</u>:

- The Code of Conduct is shared with persons served during client orientation.
- ACR believes in the importance of ethical practices within the organization. Any staff who reports waste, fraud, abuse or any other questionable practices will not be subject to reprisal by management of the organization. To assure that reprisal is not used, the organization's management team will serve as advocates for any employee who reports questionable practices. The Corporate Compliance Officer will provide assurance and oversight that there are no adverse actions toward the employee.
- The following violations of the Code of Conduct will result in termination of employment: Theft of funds, and/or physical, emotional, or sexual abuse of a client or employee.

Code of Conduct and Corporate Compliance Attestation

Assertive Community Recovery, LLC (ACR) **is committed to excellence and leadership in community mental and behavior health services.** As an employee, volunteer or vendor, I understand that I play a vital role in the success of the ACR mission and that I will be held accountable for compliance with applicable law, Georgia Department of Human Resource Division of Behavior Health and Developmental Disease (DHR DBHDD) and ACR policies and procedures. This statement summarizes the standards of conduct that ACR requires me to uphold:

- **Knowledge, understanding and compliance with the policies and procedures that apply to my work.** I agree to comply with all of the policies and procedures that relate to my work at ACR, including the Code of Conduct, Corporate Compliance and Billing Polices. I agree that if I do not know whether an action is permitted, I will ask my supervisor or review the relevant policies. Sources include the ACR Policy Manual, DHR DBHDD Policies posted on their website, https://dbhdd.georgia.gov/community-provider-manuals. The ACR policies are available online for review (supervisors can provide information on how to link the policy website). If I do not know what is permitted or required, I may contact the ACR Compliance Officer at 404-508-0078 for guidance.

- **Avoiding fraud, waste and abuse**. I will accurately and honestly perform my work for ACR, and will not engage in any activity intended to defraud anyone of money, property or services. I will not request or accept payment, either directly or indirectly, that is intended to induce referrals, or to induce the purchasing, leasing, ordering or arranging for any item or service at or from any organization or facility. I will comply with ACR policies on conflicts of interest and on interactions between vendors, State officials and staff. I will report any potential fraudulent or false claims, inappropriate billing practices, or similar concerns to my supervisor or the Compliance Office.

- **Protecting the confidentiality and security of information.** I may have access to proprietary or confidential information (including protected health information) about ACR operations, staff, and/or consumers ("sensitive information"). All of this information, in whatever form transmitted or received (e.g., oral, fax, photographic, written, electronic), must be treated by me in a confidential and secure fashion. I have completed and understand any ACR HIPAA training required for my position.

    - I will not access, release, or share sensitive information – even demographic screens with addresses and phone numbers – unless doing so is necessary as a part of my assigned duties, or I am authorized to do so by a Release of Information form. **I understand that my access to ACR systems containing sensitive information may be audited at any time**, with or without cause. I understand that I am responsible for any access that occurs using my password.

        - I will protect sensitive information. **I will not share my passwords or access to any ACR systems or applications with any other person.** I will be careful to avoid inadvertently revealing sensitive information, including avoiding discussions of sensitive information in

public places. I will not remove sensitive information from ACR without my supervisor's permission and I understand that I am responsible for maintaining the security of such information in accord with ACR standards. **If I use a portable electronic device (e.g., laptop, PDA), I will ensure that it meets ACR security standards.**

- I understand that when my employment, affiliation, visitation or assignment with ACR ends, I may not take any sensitive information with me and I may not reveal any ACR sensitive information to any third person except as permitted by a Release of Information form (in the case of individually identifiable private information) or by written release from an authorized ACR representative (in the case of proprietary information).

  - **Disclosing actual and potential conflicts of interest or commitment and complying with any plans imposed to manage those conflicts. I agree to report any potential or actual conflicts of interest or commitment, and I have reported any current potential or actual conflicts of which I am aware**. An actual or potential conflict occurs if I or a family or household member has an outside personal, professional, commercial, or financial interest. While outside relationships and activities that further ACR's clinical missions are encouraged, conflicts can arise. The existence of a conflict is not inappropriate in and of itself. However, in clinical setting, these relationships or activities can compromise or be perceived to compromise basic values of openness, integrity, independence, and public trust. I understand that for these reasons, actual or potential conflicts must be disclosed and managed to assure that they do not compromise my judgment, influence my decisions with respect to meeting client needs or ACR business, result in personal advancement at the expense of ACR, or otherwise interfere or compete with ACR's service missions, or with my ability or willingness to fulfill my responsibilities. I will disclose actual or potential conflicts of interest and conflicts of commitment as required by ACR policies. [If I am a vendor employee, I have reported and will continue to disclose any such conflicts to my employer.]

    - **I agree to treat all ACR personnel with respect, courtesy, and dignity** and will conduct myself in a professional and cooperative manner. I understand that collaboration, communication and collegiality in the workplace are essential for the provision of safe and competent consumer care. I also agree to report any disruptive or inappropriate behavior that I am subjected to or that I observe in the workplace.

I understand that if I do not comply with ACR policies and procedures or applicable law, I may be subject to immediate disciplinary or corrective action, up to and including dismissal or termination of contract. I understand that noncompliance with federal or state law may result in criminal and civil penalties against the ACR, my employer (if I am employed by another entity) and/or me personally.

Code of Conduct and Corporate Compliance Attestation

I agree to immediately report suspected noncompliance to my supervisor, or to the ACR Compliance Officer at 404-508-0078. I understand that I may also make such a report anonymously on www.AccreditationNow.com, (Anonymous Login: 10060339 Password: acr1234) In addition, you may anonymously make reports directly to:

Georgia Department of Behavioral Health & Developmental Disabilities
Two Peachtree Street, N.W.
24th Floor
Atlanta, Georgia 30303
404-657-2252

or

DBHDD Region Three Office
100 Crescent Centre Parkway Suite 900
Tucker, Georgia 30084
Phone: (770) 414-3052
Fax: (770) 414-3048

or

Office of Inspector General Fraud Hotline
OIG Hotline: 1-877-423-4746
OIG Fax: 404-463-5496
OIG Email: inspectorgeneralhotline@dhr.state.ga.us
Via the Web: online form: https://dhs.georgia.gov/dhs-oig-incident-form

I agree to cooperate with any investigation of possible noncompliance and not to withhold relevant information. ACR does not tolerate retribution or retaliation against anyone reporting suspected noncompliance in good faith. I will immediately report to my supervisor and Clinical Director or any suspension, restriction, termination, or change in status of any professional credential that I hold.

BY SIGNING BELOW, I CERTIFY THAT I AM IN COMPLIANCE WITH ALL Department of Behavior Health and Developmental Disorders (DBHDD) AND ACR POLICIES AND PROCEDURES, INCLUDING THOSE THAT REQUIRE ME TO REPORT ANY SUSPECTED NON-COMPLIANCE.

Name	**Date**
Signature	

Policy 02.03 - Contractual Relationships

I. POLICY:

Assertive Community Recovery (ACR) shall demonstrate a commitment to responsibility by contracting for services in a fair and reasonable manner. No favors will be granted or received for any contracts initiated. Contracted services shall be reviewed on an annual basis.

II. PROCEDURES:

A. Contracts shall be awarded after a minimum of two, three preferred, bids are obtained for projects greater than $1000.00.

B. Contractors shall be held to the same standards of employees while providing services for ACR.

C. Contractors shall sign a Services Agreement and Business Associate Agreement upon commencement of work acknowledging agreement to assigned project/duties and a responsibility to maintain confidentiality.

D. All contractors shall be supervised by the Executive Director or designee.

E. All contractors shall have performance evaluated no less than annually to:

1. Have the contract assessed.
2. Ensure contractor is following all policies, practices and standards.
3. Ensure contractor conforms to the policies and procedures of ACR as well as, CARF standards applicable to the services they provide.

Policy 02.04 - Cultural Competence Plan

I. POLICY:

A. Assertive Community Recovery endeavors to reflect the diversity of culture in the population it serves by recruiting and retaining personnel and providing leadership that is reflective of the specific cultures the agency serves.

B. Discrimination still exists in the Assertive Community Recovery workplace, despite historic efforts and current government legislation. Leadership Team is conscious of their responsibility to move towards an inclusive workforce, one of diversity, appreciation and valuing of all employees and clients. Recruitment is an important aspect of building diversity.

C. Assertive Community Recovery believes that cultural competency is critical to the success of the delivery of health and human services in an ever-diverse environment. The respect of an individual's cultural domains and experiences are essential to engagement with service providers.

D. Cultural competency is defined as "a set of behaviors attributes and policies enabling an agency (or individual) to work effectively in cross cultural situations". Cultural competency is further defined in the terms of Commitment, Accessibility and Relevance.

E. Assertive Community Recovery has a commitment to recruit, train, retain and advance staff on cultural competency. All new staff members will be oriented to cultural competency expectations. Both clinical and support staff will attend a yearly in-service training.

II. PROCEDURES:

A. Cultural competency will be addressed in monthly staff meetings when pertinent. Trainings will recognize that cultural differences exist between and within groups and those subgroups may think feel and behave differently and cannot and should not be measured against the dominant culture. Assertive Community Recovery as a corporation will continuously assess and explore the elimination of barriers to service. It is the responsibility of the Leadership Team to network with other human services and report back to the staff the availability of resources. These resources may include language services, funding opportunities and external trainings. The Assertive Community Recovery cultural competency plan includes services that are delivered in a manner that is relevant to the client and in a way that is meaningful and congruent with the client's language, culture belief, environment and spiritual and religious beliefs. Services

are designed to be sensitive to cultural differences in decision-making and life events. Services will involve resources that are traditional and/or nontraditional within the community. Assertive Community Recovery will maintain involvement with DHR and CARF's governing agencies, to insure continuation of progress made in establishing the guiding principles of cultural competency. Assertive Community Recovery will be aggressive in planning for recruitment, training and retaining a diverse staff.

B. The Leadership Team will annually review the cultural diversity of its staff and verify that its cultural diversity reflects the population of clients served. The annual review will take place during the December Leadership Team meeting. In the event staffing is found to be less than what it would be reflective of the population served, the targeted population would be given preferential review of application and employment opportunity. In addition to an annual review, the Leadership Team will address staffing needs with sensitivity to cultural diversity as employment opportunity needs arise.

C. The Leadership Team at Assertive Community Recovery recognizes that the retention of personnel and Administration, regardless of a person's culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status or language, is vital for continuation of expansion of the corporation. This objective is strived for via appreciating staff members through many avenues such as: verbal communication benefits and keeping salaries/percentages with current market trends and equal advancement opportunities within the organization.

D. Management and Leadership positions at Assertive Community Recovery have in the past and will continue to be filled by individuals displaying professional characteristics demonstrative of the responsibility. No candidate for leadership will be dismissed from nomination because of race, gender or other cultural considerations.

E. For the purpose of discussing cultural issues for clients and patients served by Assertive Community Recovery, the definition of culture is expanded to include more than race, skin color and national boundaries. When the definition of culture is expanded to include common values, traditions, myths and personal histories of a group of people, it is possible to identify other cultures in the treatment population: gender-based groups, age-based groups (i.e., GenX, baby boomers, senior citizens), job related groups (i.e., blue collar, white collar, retired), drug-of-choice groups (alcoholics, alcohol abuse, drug addicts, potheads), urban dwellers, rural dwellers and recovery groups.

F. Assertive Community Recovery recognizes, appreciate and accept that cultural diversity is a universal aspect of all human life. Everyone in the world today has the right to have and enjoy a cultural preference.

III Corporation Standard

A Cultural Competence Plan has been developed, approved and integrated within the overall organization to assure attainment of cultural competence within manageable but concrete timelines. The plan shall include measures related to the standards in each of the following Cultural Competence Domains: Organizational Management & Staffing and Service Delivery.

IV Guidelines

Conduct initial and ongoing organizational self-assessments of Cultural Competence-related activities and integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, client satisfaction assessments, and outcome-based evaluations.

V Plan

A. Is developed with the participation and representation of the Leadership Team, front-line staff, clients and/or their families, and community stakeholders;

B. Includes a process for integrating the Cultural Competence Plan and including the principles of cultural competency in all aspects of organizational strategic planning and in any future planning process;

C. Includes a process for determining unique regionally-based knowledge, needs, and socioeconomic factors within the communities/populations served using existing agency databases, surveys and community needs assessments;

D. Identifies service modalities and models, which are appropriate and acceptable to the cultural communities served;

E. Ensures identification and involvement of community resources, for purposes of integrated consumer support and service delivery;

F. Assures cultural competence at each level of service within the system;

G. Includes a stipulation of adequate and culturally diverse staffing for all staff, clerical through executive management;

H. Ensures development of a plan to integrate ongoing training and staff development into the overall Cultural Competency Plan; and

I. Includes ongoing monitoring of indicators to assure equal access, comparability of services, and outcomes across all services provided through the organization.

VI Management/Staffing Standard

All levels of the organization including management, clinical staff and support staff shall be:

A. Representative of community demographics: Organization composition is proportionally representative of the consumer populations to be served.

B. Knowledgeable: Training and development in the area of cultural competence is implemented at all levels.

C. Accountable: All levels are accountable for the successful implementation of cultural competence plan.

VII Guidelines

A. Identify the skills and knowledge needed to provide culturally competent services to organization's target population. Include them in job announcements and job descriptions, and recruit based upon them.

B. Establish, promote, support, and encourage visibility of all cultural groups, and effectively communicate an inclusive, non-discriminatory work place environment.

C. Ensure the comprehensive and easily accessible procedure, which are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts, are in place for staff to address and resolve concerns. This includes concerns related to culture competence practices within the organization.

D. Identify resources to implement staff, volunteer and board cultural competence training plan. This may include developing agreements with other agencies for cross agency training.

E. Staff training and development in the areas of cultural competence are implemented at all levels and across disciplines, for leadership, as well as for clinical and support staff. The cultural competence training is incorporated into an ongoing organization staff training plan. This plan is tracked annually.

F. Suggested curriculum and/or training topics include:

    1. Unique stressors, for example: war, trauma, violence, socioeconomic status, political unrest, aspects of cultural survival and maintenance, racism, and discrimination;

    2. The effects of acculturation on individuals;

    3. How class, ethnicity, social status and other distinguishing factors influence behavior, attitudes, values and belief systems;

4. Dynamics of language use, including: conceptual frameworks of monolingual and bilingual individuals, nuances of verbal and nonverbal language, speech patterns and communication styles, and literacy level;
5. Issues of stigma to various groups and subgroups;
6. Other culturally based behaviors and/or circumstances including: help-seeking behaviors, varying effects of commonly used medications on individuals, role and manifestation of spiritual or traditional beliefs.
7. Practical strategies for adapting service delivery to various cultural groups.

G. Employment recruitment, retention and promotion strategies are targeted to the population demographics of the community.

H. For purposes of accountability, the Cultural Competence Plan is integrated into an overall agency strategic plan, continuing development of cultural competence is reported.

VIII Service Delivery Standard

The organization's services shall be culturally:

A. Accessible: Organizations shall ensure that all potential clients have the opportunity to use all services provided by the agency.

B. Appropriate: Organizations shall ensure that client receive, from all service providers, effective, understandable and respectful service that is provided in a manner compatible with their cultural beliefs and practices and preferred language.

C. Representative: Client demographics are representative of the agency's services and geographic area.

IX Guidelines

A. Know and be able to demonstrate knowledge of the socioeconomic issues of various cultural groups in your service area.

B. Review fee structure to determine ability of pay is a barrier to accessing services.

C. Programs provide culturally inviting environments (e.g., décor, ambiance, cultural symbols) as measured by consumer satisfactions surveys.

D. All program services are relevant and respectful of cultural factors and backgrounds.

E. Ensure services for clients are compatible with cultural framework and community environment of client and family members. Clients participate in the development of their Treatment Plans.

F. Provide to consumers in their language both verbal offers and written notices informing them of their rights to receive language assistance services.

G. Offer and provide language assistance services, including bilingual staff and/or interpreter services, in a timely manner during all hours of operation. Assure the competence of language assistance provided consumers by interpreters and bilingual staff.

H. Make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service are. Incorporate consumer feedback into the materials to ensure they are culturally relevant.

I. Services are located in areas readily accessible to and are actively marketed to a wide range of cultural groups in the community.

J. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by consumers.

Form 02.04a - Cultural Competency Assessment

Culturally Competent Care

Standard #1

Healthcare organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Assessment Inquiry:

What evidence do you have that your patients/consumers receive effective, understandable, and respectful care from all staff members of your healthcare organization?

a. In what ways do you provide care to patients that reflect their cultural health beliefs and practices?

b. What strategies do you employ to ensure a patient's understanding of the healthcare services when the patient's preferred language is not English?

Standard #2

Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Assessment Inquiry:

What are your healthcare organization's strategies to recruit, retain, and promote a diverse staff at all levels?

a. How effective and recent is your implementation plan? How do you measure its success?

b. In what ways is leadership in your healthcare organization representative of the demographic characteristics of your service area? Is current representation sufficient? How do you know?

Standard #3

Healthcare organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Assessment Inquiry:

What evidence do you have that staff at all levels and across all disciplines in your healthcare organization receive ongoing education, training, and supervision to assure competence in delivering culturally and linguistically appropriate services to patients?

Language Access Services

Standard #4

Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Assessment Inquiry:

What kind of language assistance, including bilingual staff and interpreter services, do you offer and provide to patients whose English proficiency may be limited?

What evidence do you have that this assistance is offered and provided.

a. At no cost?

b. At all points of contact?

c. In a timely manner?

d. During all hours of operation?

Standard #5

Healthcare organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Assessment Inquiry:

In what ways do you let patients/clients/consumers/persons served know, in their preferred language, using both verbal and written notices, that they have a right to receive language assistance while in the office, on the telephone, and to read and understand all pamphlets, brochures, and other written materials?

What specifically do you do to check on whether these approaches are actually being utilized and whether they are working?

Standard #6

Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/ consumer).

Assessment Inquiry:

When you provide language assistance for patients whose English proficiency is limited …

a. What do you do to make sure the patient is receiving competent assistance?

b. What do you do to make certain that, unless the patient has expressly requested family or friends to provide language services, interpreters and bilingual staff are available to assist?

Standard #7

Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Assessment Inquiry:

a. Are your print materials, including signs and posters, available and/or posted in the languages of the communities you serve?

b. Are these materials placed or posted so that they may be easily seen and understood by patients whose English proficiency may be limited?

c. How do you seek feedback from patients whose English proficiency may be limited to check whether your print materials are useful to them?

Organizational Supports for Cultural Competence

Standard #8

Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management oversight mechanisms to provide culturally and linguistically appropriate services.

Assessment Inquiry:

a. Does your organization have a written strategy plan?

b. If yes, does that plan include strategies to strengthen and promote cultural competency, including gathering the information necessary to do so?

c. If yes, does it contain specific criteria for success against which outcomes are measured?

d. If yes, does it provide for specific ways in which management sets cultural competency related goals and holds itself accountable for the plan's outcomes?

Standard #9

Healthcare organizations should conduct initial and ongoing organizational self-assessments of culturally and linguistically appropriate activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Assessment Inquiry:

a. Have you ever conducted an organizational self-assessment in the area of cultural competence?

b. If yes, when was the last time you measured your progress against the initial assessment?

c. What ways do you integrate cultural and linguistic competence-related measures into your:

   (1) internal audits
   (2) performance improvement system
   (3) patient satisfaction surveys

Standard #10

Healthcare organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Assessment Inquiry:

a. In what ways do you ensure that data on race, ethnicity, and spoken and written languages are collected in health records?

b. What evidence is there that the collected data is integrated into the organization’s management information system?

c. Does the information you collect identify population groups within your service area?

d. Describe specific ways in which the information you collect helps you monitor patient/consumer needs, utilization, quality of care, and outcome patterns related to.

Standard #11

Healthcare organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Assessment Inquiry:

a. Do you maintain a current demographic, cultural, and epidemiological profile of community your serve? For example, do you reference:

   (1) Census figures
   (2) Voter registration data
   (3) School enrollment profiles
   (4) County and state health status reports
   (5) Data from community agencies and organizations

b. How often do you conduct qualitative and quantitative needs assessments to plan for and implement services that respond to the cultural and linguistic characteristics of your service area?

c. When did you last conduct language-appropriate focus groups, interviews, and surveys and what changes did you make based on data from these activities?

Standard #12

Healthcare organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate

community and patient/consumer involvement in designing and implementing culturally and linguistically appropriate activities.

Assessment Inquiry:

a. Describe some of the participatory, collaborative partnerships you have developed with the communities you serve?

b. What are some of the formal and informal mechanisms that you use to facilitate community and patient/consumer involvement in designing and implementing cultural competency activities, and how do you measure their impact and success?

Standard #13

Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Assessment Inquiry:

a. In what ways do you assure that conflict and grievance resolution processes are culturally and linguistically sensitive?

b. How do your conflict and grievance resolution processes effectively identify, prevent, and resolve cross-cultural conflict or complaints by patients and consumers?

c. In what ways does your organization work to anticipate areas of conflict that may arise from cross-cultural differences between patients and the organization or your staff?

d. What kind of grievance and conflict management training does staff receive?

e. Do you give a language-appropriate notice to each patient concerning his/her right to file a complaint or grievance?

f. Does your organization have an ombudsman? Do staff and patients know how to access his/her services?

Standard #14

Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the culturally and linguistically appropriate services standards and to provide public notice in their communities about the availability of this information.

Assessment Inquiry:

a. Do you share information with the public about your progress and your successful innovations in implementing the cultural competency standards?

b. Do you provide public notice in your community about the fact that you have this information available?

Policy 02.05 - Corporate Compliance

I. POLICY:

A. It is the policy of Assertive Community Recovery, LLC (ACR) to provide services that fully comply with all federal, state, and local regulations and applicable laws, and to adhere to explicit ethical standards throughout all facets of the organization's operations. ACR will ensure these conditions of operation are met through an organized and ongoing comprehensive corporate compliance program.

B. ACR's Corporate Compliance Program seeks to meet the following overall goals:

1. Maintain and enhance the quality of services.
2. Demonstrate a sincere effort to comply with all applicable laws.
3. Revise and develop new policies and procedures to enhance compliance.
4. Enhance communications with governmental entities to ensure compliance.
5. Empower all involved parties to prevent, detect, respond to, report, and resolve conduct that does not conform to applicable laws and regulations, and the organization's ethical standards/code of conduct.
6. Establish mechanisms for staff members to ensure that questions and concerns about compliance issues are appropriately addressed.

II. PROCEDURES:

A. Organizational Responsibilities:

1. Corporate Compliance Officer: The Corporate Compliance Officer (CCO) shall provide leadership and oversight of the Corporate Compliance Program. The CCO's duties shall include, but not be limited to:

a) Serve as the organization's internal and external point of contact for overall corporate compliance issues.

b) Develop, implement, and monitor the organization's Corporate Compliance Plan, including internal and external monitoring, auditing, investigative and reporting processes, procedures, and systems.

c) Provide regular communication to the Leadership Team concerning all areas of the Corporate Compliance Program.

d) Provide specific guidance and ongoing education to staff members who are expected to know and comply with specific laws and guidelines in their regular job duties.

e) Ensure that mechanisms for preventing, detecting, reporting, and resolving compliance issues are operating in a functional manner.

f) Ensure that the organization's reporting mechanisms enhance and encourage active participation of all staff members, and provide confidentiality in the reporting process.

g) Ensure that all suspected violators and/or violations are handled according to documented policy and resolved in a manner that ensure the integrity of the organization's compliance with applicable guidelines and laws.

h) Submit an annual report to the Leadership Team that includes a summary of all allegations, investigations, and/or complaints processed in the preceding 12 months, a complete description of all corrective actions taken, and any recommendations for changes to the organization's policies and/or procedures.

i) In performance of his/her duties, the CCO shall have direct and unimpeded access to the organization's legal counsel and/or accounting firm, for matters pertaining to corporate compliance.

2. Compliance Officer's Job Duties:. The duties of the CCO, or designee, will include, but not be limited to:

a) Ongoing identification and assessment of compliance systems and issues.

b) Plan and provide guidelines for development of service specific compliance procedures through the development, revision, and ongoing monitoring of the organizational Corporate Compliance policies and process.

c) Plan and provide support for educational training and programming.

d) Disseminate compliance information.

e) Provide controls to prevent and reduce errors, and to identify wrongdoing.

f) Receive, evaluate, and respond to reports of potential violations.

g) Work with administrative and clinical leadership to implement remedial actions, and take appropriate corrective and disciplinary actions.

3. The CEO/Executive Director will have the ultimate authority and responsibility for corporate compliance.

B. Employee Training:

1. The Corporate Compliance Program will be fully integrated into the organization's education and training systems through the following processes:

2. All new employees will review the Corporate Compliance Program Policy and the organization's Code of Conduct as part of the new employee orientation process.
3. All staff members will review the organization's Code of Conduct as part of their annual performance review evaluations.
4. Team Leaders and program coordinators will inform staff members of specific ongoing compliance issues that pertain to their job duties at regularly scheduled staff meetings.
5. All staff members will participate in ongoing compliance in-service presentations and competency-based trainings.
6. Regular publication of reporting mechanisms will occur throughout the organizations communication systems. These will include, but not be limited to, email notification, internal memos, and postings on bulletin boards in staff and public areas.
7. Employee exit interviews will include compliance-related questions.

C. Monitoring and Auditing:

1. ACR will utilize the CCO to ensure that it conducts business in an ethical manner and ensure that any questionable business practices are thoroughly investigated through the organization's written investigation procedures.
2. All programs shall implement internal controls, including monitoring activities to ensure compliance with the organization's program.
3. Internal self-audits will include, but not be limited to, fiscal services, marketing, contractual services, health and safety practices, use of agency resources, confidentiality, dual relationships, and medical necessity.
4. Ongoing monitoring and auditing activities will be reported to the (Insert appropriate entity here) for review and appropriate actions, if necessary.

D. Reporting System:

1. ACR will provide mechanisms to assist staff members and/or agents in reporting suspected violations of possible criminal conduct or violation of the organizational code of ethics by persons within the organization, without fear of retribution.
2. Specific processes of reporting suspected violations include the following:
    a) Web/Server Based: All employees can access www.AccreditationNow.com web site to report suspected violations. A link is available on the web site that will allow the reporting party to provide anonymous information which will be forwarded to the corporate compliance officer. The Anonymous Login ID and Password for Assertive Community Recovery, LLC is Login:10060339, Password: acr1234

b) Compliance Forms/Letters: All employees will be given self-addressed stamped envelopes and compliance reporting forms to use for submitting information to the corporate compliance officer concerning possible violations.

E. Investigation Procedures:

1. The CCO shall initiate and conduct investigations of all reported alleged incidents within 72 hours of becoming aware of an incident that may be in violation of this policy.
2. Upon receiving information of an alleged incident or violation, the COO will inform the CEO/Leadership Team of the allegation.
3. If a member of the CEO/Leadership Team is directly connected to the alleged incident that is being investigated, he/she will be excused from the team/investigation until the final outcome and corrective action plan has been completed.
4. All information concerning the alleged incident with be held in strict confidentiality by all parties involved in the process, and will not be shared with any other staff member.
5. The CCO will conduct an initial investigation through an interview process with staff members who are assigned to duties and areas related to the alleged violation.
6. The CCO will determine from the initial investigation whether the situation would benefit from the involvement of the organization's legal counsel in the investigation process, and recommend such action to the CEO/Executive Director, should it be appropriate.
7. The employee is notified that there is a complaint and, if warranted by the initial information and involves a direct service situation, may be instructed to not continue direct services with a client until the issue is resolved. The supervisor assisting with the investigation will take primary responsibility for helping the client with access to a clinician that can provide services during the investigation should a change in clinicians be warranted.
8. If the suspected violation of the Code of Conduct involves the executive management of the organization, the organization will enlist assistance from their legal counsel to serve as the final approval of outcome and recommendations.
9. The investigation may involve interviews with witnesses and clients, as well as reviewing other relevant information. At all times the client's rights will be respected.
10. If at any time during the investigation it is determined that the client's rights have been violated, the appropriate advocacy representative or entity will be immediately contacted to begin their own investigation process according to applicable laws and guidelines.

11. If involved, the organization's legal counsel will help ensure the confidentiality and attorney-client privilege of any information which may be complied, help management focus on critical issues which should be investigated, and help design a strategy for effectively using the findings of the investigation.
12. Following an investigation, the CCO will file a report to the CEO/Leadership Team that will include a summary of all allegations, results of the investigation, and recommendations for corrective actions.
13. The CCO, the CEO/Executive Director, and the supervisor of the staff member(s) involved in the incident will review the recommendations and develop a corrective plan of action.
14. Should the investigation indicate a serious violation of policy, the organization's legal counsel will advise the CEO/Executive Director with regard to the need to self-report the violation to the appropriate government regulatory agency, and will assist in the process should it be necessary.
15. A written report will be compiled and submitted within fourteen (14) days from the notification of the complaint. The report will detail the following:
    a) The nature of the complaint, including time, date, persons involved, services involved.
    b) The person whom the complaint is lodged against.
    c) Results of persons interviewed and investigation of circumstances surrounding the incident.
    d) A recommendation based on the gathered information.
16. The Corporate Compliance Officer will make one of three possible findings in the recommendation to The (Insert appropriate entity here):
    a) Founded: The suspected violation of the Code of Conduct was found to have occurred.
    b) Unfounded: The suspected violation of the Code of Conduct was found not to have occurred.
    c) Undetermined: It cannot be determined whether or not a violation of the Code of Conduct has occurred.
17. Once approved by the CEO/Executive Director, the supervisor will inform the employee, who is the subject of the investigation, of the outcome of the investigation.
18. If the finding was unfounded, the paperwork of the complaint and the investigation will be destroyed.
19. If the finding was undetermined, the supervisor will adjust the supervision of the employee to a level necessary to ensure that the suspected behavior is not occurring. The employee will be informed of the details and will be actively involved with the supervisor in this process.

20. If it is determined that the suspected violation is a consumer rights violation, then the investigation, notification, and appeal procedure will follow the consumers right's policy and procedures.
21. When an investigation of ethical complaints are found to have merit, the incident will be reported to the executive management as a critical incident, and will be reviewed within the appropriate format to assist in quality improvement, risk management, and corrective measures.
22. The CCO will monitor and evaluate the corrective plan interventions through consistent communication and contact with the supervisor in charge, and will reevaluate the actions/corrections on a monthly basis.
23. The CCO will provide updates of the situation to the CEO/Executive Director until the situation has been resolved.
24. The incident, investigation, and outcome will be included in the annual corporate compliance report to the CEO/Leadership Team.
25. The CEO/Executive Director will utilize all information consistent with an incident, investigation, and outcome to recommend revision and development of policy, procedures, and guidelines in the area of corporate compliance.

F. Enforcement and Discipline:

1. Remedial Actions:

    a) Remedial actions are not disciplinary and are done to correct mistakes, and enhance compliance with the Corporate Compliance Program and State and Federal regulations. In most cases, remedial actions are designed to improve performance of individual staff members. Upon investigating what appears to be behavior requiring remedial actions, the CCO will clarify policies, and will review, and revise if necessary, administrative procedures to prevent future errors.

    b) If remedial action is deemed necessary, the affected staff member will be notified, prior to the initiation of the action, and informed of the concerns regarding his/her performance.

    c) Examples of behaviors that could require remedial action might include but not limited to, failure of an individual to understand and carry out organizational-wide required procedures and policies, inappropriate or improper implementation of the organization's specific corporate compliance policies and procedures, ambiguous communications regarding job performance expectations, or negligent behavior.

    d) Examples of remedial actions may include, but not be limited to staff members required to take part in an education program focused on the problem area, future money management handled in a specifically designated manner, a staff member reassigned, or

a change in duty until remediation has successfully corrected the error.

2. Corrective or Disciplinary Actions:

    a) In cases of repeated violations of intentional misconduct, or after documented remedial actions have failed to correct the problem, the organization will initiate corrective or disciplinary actions where necessary to address wrongdoing or malfeasance. The initiation of corrective or disciplinary action by the organization does not preclude or replace any criminal proceedings that may be taken by legal authorities.

    b) Should the organization initiate corrective or disciplinary action, it will do so in accordance with existing and applicable personnel policies.

G. Prevention:

1. Education and training will serve as the core of ACR prevention efforts to ensure minimal violations of law, ethics, and code of conduct. Prevention efforts will include, but not be limited to:

    a) New employee orientation training.

    b) Training related to the staff members' specific position.

    c) Documentation of competency in required areas through performance appraisals and/or competency based exams.

    d) Routine, targeted, and random audits of systems and medical charts.

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email: ACR_Admin@ACRHealthGA.com

2568 Park Central Blvd
Decatur, Georgia 30035-3919

Policy 02.05.1 - Corporate Compliance Officer Duties and Compliance Procedures

I. POLICY:

A. It is the policy of ACR Health Services to provide services that fully comply with all federal, state, and local regulations and applicable laws, and to adhere to explicit ethical standards throughout all facets of the organization's operations. ACR Health Services will ensure these conditions of operation are met through an organized and ongoing comprehensive corporate compliance program.

B. ACR Health Services' Corporate Compliance Program seeks to meet the following overall goals:

1) Maintain and enhance the quality of services.

2) Demonstrate a sincere effort to comply with all applicable laws.

3) Revise and develop new policies and procedures to enhance compliance.

4) Enhance communications with governmental entities to ensure compliance.

5) Empower all involved parties to prevent, detect, respond to, report, and resolve conduct that does not conform to applicable laws and regulations, and the organization's ethical standards/code of conduct.

6) Establish mechanisms for staff members to ensure that questions and concerns about compliance issues are appropriately addressed.

II. PROCEDURES:

A. Organizational Responsibilities:

1) Corporate Compliance Officer: **Trese Harris** shall serve as the Corporate Compliance Officer (CCO) and provide leadership and oversight of the Corporate Compliance Program. The CCO's duties shall include, but not be limited to:

a. Serve as the organization's internal and external point of contact for overall corporate compliance issues.

b. Develop, implement, and monitor the organization's Corporate Compliance Plan, including internal and external monitoring, auditing, investigative and reporting processes, procedures, and systems.

c. Provide regular communication to the Leadership Team concerning all areas of the Corporate Compliance Program.

d. Provide specific guidance and ongoing education to staff members who are expected to know and comply with specific laws and guidelines in their regular job duties.

e. Ensure that mechanisms for preventing, detecting, reporting, and resolving compliance issues are operating in a functional manner.

f. Ensure that the organization's reporting mechanisms enhance and encourage active participation of all staff members, and provide confidentiality in the reporting process.

g. Ensure that all suspected violators and/or violations are handled according to documented policy and resolved in a manner that ensure the integrity of the organization's compliance with applicable guidelines and laws.

h. Submit an annual report to the Leadership Team that includes a summary of all allegations, investigations, and/or complaints processed in the preceding 12 months, a complete description of all corrective actions taken, and any recommendations for changes to the organization's policies and/or procedures.

i. In performance of his/her duties, the CCO shall have direct and unimpeded access to the organization's legal counsel and/or accounting firm, for matters pertaining to corporate compliance.

2) Compliance Officer's Job Duties: The duties of the CCO, or designee, will include, but not be limited to:

a. Ongoing identification and assessment of compliance systems and issues.

b. Plan and provide guidelines for development of service specific compliance procedures through the development, revision, and ongoing monitoring of the organizational Corporate Compliance policies and process.

c. Plan and provide support for educational training and programming.

d. Disseminate compliance information.

e. Provide controls to prevent and reduce errors, and to identify wrongdoing.

f. Receive, evaluate, and respond to reports of potential violations.

g. Work with administrative and clinical leadership to implement remedial actions, and take appropriate corrective and disciplinary actions.

3) The CEO will have the ultimate authority and responsibility for corporate compliance.

B. <u>Employee Training:</u>

1) The Corporate Compliance Program will be fully integrated into the organization's education and training systems through the following processes:

a. All new employees will review the Corporate Compliance Program Policy and the organization's Code of Conduct as part of the new employee orientation process.

b. All staff members will review the organization's Code of Conduct as part of their annual performance review evaluations.

c. Regional directors and program coordinators will inform staff members of specific ongoing compliance issues that pertain to their job duties at regularly scheduled staff meetings.

d. All staff members will participate in ongoing compliance in-service presentations and competency-based trainings.

e. Regular publication of reporting mechanisms will occur throughout the organizations communication systems. These will include, but not be limited to, email notification, internal memos, and postings on bulletin boards in staff and public areas.

f. Employee exit interviews will include compliance-related questions.

C. <u>Monitoring and Auditing:</u>

1) ACR Health Services will utilize the CCO to ensure that it conducts business in an ethical manner and ensure that any questionable business practices are thoroughly investigated through the organization's written investigation procedures.

2) All programs shall implement internal controls, including monitoring activities to ensure compliance with the organization's program.

3) Internal self-audits will include, but not be limited to, fiscal services, marketing, contractual services, health and safety practices, use of agency resources, confidentiality, dual relationships, and medical necessity.

4) Ongoing monitoring and auditing activities will be reported to the CEO for review and appropriate actions, if necessary.

D. <u>Reporting System:</u>

1) ACR Health Services will provide mechanisms to assist staff members and/or agents in reporting suspected violations of possible criminal conduct or violation of the organizational code of ethics by persons within the organization, without fear of retribution.

2) Specific processes of reporting suspected violations include the following:

a. **Web/Server Based:** All employees can access the ACR Health Services employee's web site to report suspected violations. A link will be available on the web site that will allow the reporting party to provide anonymous information which will be forwarded to the corporate compliance officer.

b. **Compliance Forms/Letters:** All employees will be given self-addressed stamped envelopes and compliance reporting forms to use for submitting information to the corporate compliance officer concerning possible violations.

E. <u>Investigation Procedures:</u>

1) The CCO shall initiate and conduct investigations of all reported alleged incidents.

2) The investigation of the reported alleged incident will begin within three (3) days of the CCO being informed of the incident.

3) Upon receiving information of an alleged incident or violation, the COO will inform the CEO) of the allegation.

4) If a member of the Leadership Team is directly connected to the alleged incident that is being investigated, he/she will be excused from the team/investigation until the final outcome and corrective action plan has been completed.

5) All information concerning the alleged incident with be held in strict confidentiality by all parties involved in the process, and will not be shared with any other staff member.

6) The CCO will conduct an initial investigation through an interview process with staff members who are assigned to duties and areas related to the alleged violation.

7) The COO will determine from the initial investigation whether the situation would benefit from the involvement of the organization's legal counsel in the investigation process, and recommend such action to the CEO, should it be appropriate.

8) The employee is notified that there is a complaint and, if warranted by the initial information and involves a direct service situation, may be instructed to not continue direct services with a client until the issue is resolved. The supervisor assisting with the investigation will take primary responsibility for helping the client with access to a clinician that can provide services during the investigation should a change in clinicians be warranted.

9) If the suspected violation of the Code of Conduct involves the executive management of the organization, the organization will enlist assistance from their legal counsel to serve as the final approval of outcome and recommendations.

10) The investigation may involve interviews with witnesses and clients, as well as reviewing other relevant information. At all times the client's rights will be respected.

11) If at any time during the investigation it is determined that the client's rights have been violated, the appropriate advocacy representative or entity will be immediately contacted to begin their own investigation process according to applicable laws and guidelines.

12) If involved, the organization's legal counsel will help ensure the confidentiality and attorney-client privilege of any information which may be complied, help management focus on critical issues which should be investigated, and help design a strategy for effectively using the findings of the investigation.

13) Following an investigation, the CCO will file a report to the Leadership Team that will include a summary of all allegations, results of the investigation, and recommendations for corrective actions.

14) The CCO, the CEO and the supervisor of the staff member(s) involved in the incident will review the recommendations and develop a corrective plan of action.

15) Should the investigation indicate a serious violation of policy, the organization's legal counsel will advise the CEO and/or if appropriate the CCO with regard to the need to self-report the violation to the appropriate government regulatory agency, and will assist in the process should it be necessary.

16) A written report will be compiled and submitted within fourteen (14) days from the notification of the complaint. The report will detail the following:

a. The nature of the complaint, including time, date, persons involved, services involved.

b. The person whom the complaint is lodged against.

c. Results of persons interviewed and investigation of circumstances surrounding the incident.

d. A recommendation based on the gathered information.

17) The Corporate Compliance Officer (CCO) will make one of three possible findings in the recommendation to the CEO:

a. Founded: The suspected violation of the Code of Conduct was found to have occurred.

b. Unfounded: The suspected violation of the Code of Conduct was found not to have occurred.

c. Undetermined: It cannot be determined whether or not a violation of the Code of Conduct has occurred.

18) Once approved by the CEO the supervisor will inform the employee, who is the subject of the investigation, of the outcome of the investigation.

19) If the finding was unfounded, the paperwork of the complaint and the investigation will be destroyed.

20) If the finding was undetermined, the supervisor will adjust the supervision of the employee to a level necessary to ensure that the suspected behavior is not occurring. The employee will be informed of the details and will be actively involved with the supervisor in this process.

21) If it is determined that the suspected violation is a consumer right's violation, then the investigation, notification, and appeal procedure will follow the consumers right's policy and procedures.

22) When an investigation of ethical complaints is found to have merit, the incident will be reported to the executive management as a critical incident, and will be reviewed within the appropriate format to assist in quality improvement, risk management, and corrective measures.

23) The CCO will monitor and evaluate the corrective plan interventions through consistent communication and contact with the supervisor in charge, and will reevaluate the actions/corrections on a monthly basis.

24) The CCO will provide updates of the situation to the CEO until the situation has been resolved.

25) The incident, investigation, and outcome will be included in the annual corporate compliance report to the Leadership Team.

26) The CCO will utilize all information consistent with an incident, investigation, and outcome to recommend revision and development of policy, procedures, and guidelines in the area of corporate compliance.

F. <u>Enforcement and Discipline:</u>

1) Remedial Actions:

a. Remedial actions are not disciplinary and are done to correct mistakes, and enhance compliance with the Corporate Compliance Program and State and Federal regulations. In most cases, remedial actions are designed to improve performance of individual staff members. Upon investigating what appears to be behavior requiring remedial actions, the CCO will clarify policies, and will review, and revise if necessary, administrative procedures to prevent future errors.

b. If remedial action is deemed necessary, the affected staff member will be notified, prior to the initiation of the action, and informed of the concerns regarding his/her performance.

c. Examples of behaviors that could require remedial action might include but not limited to, failure of an individual to understand and carry out organizational-wide required procedures and policies, inappropriate or improper implementation of the organization's specific corporate compliance policies and procedures, ambiguous communications regarding job performance expectations, or negligent behavior.

d. Examples of remedial actions may include, but not be limited to staff members required to take part in an education program focused on the problem area, future money management handled in a specifically designated manner, a staff member reassigned, or a change in duty until remediation has successfully corrected the error.

2) Corrective or Disciplinary Actions:

e. In cases of repeated violations of intentional misconduct, or after documented remedial actions have failed to correct the problem, the organization will initiate corrective or disciplinary actions where necessary to address wrongdoing or malfeasance. The initiation of corrective or disciplinary action by the organization does not preclude or replace any criminal proceedings that may be taken by legal authorities.

f. Should the organization initiate corrective or disciplinary action, it will do so in accordance with existing and applicable personnel policies.

G. <u>Prevention:</u>

1) Education and training will serve as the core of ACR Health Services prevention efforts to ensure minimal violations of law, ethics, and code of conduct. Prevention efforts will include, but not be limited to:

a. New employee orientation training.

b. Training related to the staff members' specific position.

c. Documentation of competency in required areas through performance appraisals and/or competency-based exams.

d. Routine, targeted, and random audits of systems and medical charts.

Policy 02.06 - Corporate Compliance/Billing Code of Conduct

I. POLICY:

In keeping with Assertive Community Recovery, ACR mission, all employees and contractors, herein referred to as personnel, shall comply with the following billing guidelines regarding waste, fraud, abuse. Instances of non-compliance shall be reported immediately and corrective action taken in a timely manner.

II. PROCEDURES:

A. ACR personnel shall deal openly and honestly with the fellow associates, clients, contractors, government entities and others.

B. ACR personnel shall maintain high standards of business and ethical conduct in accordance with applicable federal, state, and local laws and regulations including fraud, waste, and abuse.

C. ACR personnel shall practice good faith in transactions occurring during the course of business

D. ACR personnel shall preserve client confidentiality unless there is written permission to divulge information, except as required by law.

E. ACR personnel shall ensure that professional services provided are appropriate, clear and properly documented.

F. ACR personnel shall maintain a working knowledge of laws and regulations regarding third party billing.

G. ACR personnel shall ensure that client records clearly document services performed and accurate time frames.

H. ACR personnel shall ensure that only bills that reflect accurate and properly documented services are submitted.

I. ACR personnel shall only submit bills when appropriate documentation has been maintained and is available for audit and review.

J. ACR personnel shall ensure that third party bills are submitted in accordance with third party reimbursement policies.

K. ACR personnel shall cooperate with and participate in quality check to monitor accurate coding with respect to documented services provided and to guard against double billing.

L. ACR management shall ensure billing codes are in compliance with applicable third party regulations.

M. ACR personnel shall follow all informative and relevant guidelines for billing. These guidelines shall be revised regularly to reflect regulatory/third party payer updates.

N. ACR management shall assure monies received relate solely to entitled reimbursement.

O. ACR management shall ensure that credit balances will be processed timely and if deemed proper, remitted to the appropriate payer.

P. ACR personnel shall ensure a compensation structure that does not provide incentives to improperly up-code claims is followed.

Q. ACR personnel shall follow all established policies and procedures to assure compliance with all applicable statues, regulations, program requirements and private payer plans regarding cost report issues shall be followed.

R. ACR management ensures mechanisms shall be followed to assure accurate reporting of bad debts in accordance with regulatory guidelines.

S. ACR management shall assure all staff are informed and accept this Billing Code of Conduct via signature of the Statement of Understanding of Compliance and Ethical, Business, and Billing Code of Conduct. However, at no time is this Code of Conduct to be followed as a replacement for sound ethical and professional judgment.

ACR personnel wanting to report suspected violations of the Billing Code of Conduct may contact the **Compliance Officer, Trese Harris at 404-508-0078** or email tharris@AssertiveRecovery.com or submit a confidential report by using the online Corporate Compliance Reporting System through www.accrediatonnow.com; Anonymous Login ID and Password for Assertive Community Recovery, LLC is Login:10060339 Password: acr1234

T. Time frames for responding shall be the same as those set for responding to grievances/complaints, i.e., the Compliance Officer shall compile a written response within 10 days from receipt of the allegation.

U. If the complaint does not feel satisfied with the response. They may appeal to the Chief Executive Officer (CEO) requesting a review of the allegation. The CEO shall have 15 days to review the details and provide a written response to the complainant.

V. If the decision of the CEO is not acceptable, the complainant may contact the State of Georgia through the agencies listed in Paragraph Y below.

W. ACR personnel shall be informed that an allegation will not result in any retaliatory action. ACR contractual personnel shall be held to the same standards as ACR personnel and may also make an allegation without fear of retaliation.

X. In addition, all individuals have the right to file reports directly to:

Georgia Department of Behavioral Health & Developmental Disabilities
Two Peachtree Street, N.W.
24th Floor
Atlanta, Georgia 30303
404-657-2252

or

DBHDD Region Three Office
100 Crescent Centre Parkway Suite 900
Tucker, Georgia 30084
Phone: (770) 414-3052
Fax: (770) 414-3048

or

Office of Inspector General Fraud Hotline
OIG Hotline: 1-877-423-4746
OIG Fax: 404-463-5496
OIG Email: inspectorgeneralhotline@dhr.state.ga.us
Via the Web: online form: https://dhs.georgia.gov/dhs-oig-incident-form

Policy 02.07 - Corrective Action Plans

I. POLICY:

ACR will always respond to any request from any governing body in regards to submitting a corrective action plan upon the completion of any given survey.

II. PROCEDURES:

A. ACR will comply with the regulating bodies that may request a Corrective Action Plan (CAP) which may include but not limited to the following:

1. ACR is found to be out of compliance with contract or working agreement requirements.
2. ACR is below the standard as outlined by the regulatory body.
3. A trend of sub-standard performance has been identified.
4. ACR has failed to perform any of the contractually required services.
5. ACR has failed to develop, produce, and /or deliver to the regulating body any requested statements, reports, data, data corrections, accountings, claims, and/or documentation.
6. ACR has failed to implement corrective action required by the regulating body within prescribed time frames.

B. Corrective action plans developed by ACR must be submitted for approval by the date established by the regulating body or ACR has requested and received approval in writing for an extension in the date that the CAP shall be submitted. A request for extension must be approved by the Executive Director or the Clinical Director before submitting to any outside agency. At its discretion, the regulating body may extend or reduce the time allowed for corrective action depending upon the nature of the situation. ACR will abide by any decision made by regulating agencies.

C. Corrective action plans may require modification of any policies or procedures by ACR relating to the fulfillment of its obligations as identified by regulatory agencies.

D. The Corrective Action Plan will include:
    1. Date of the Plan
    2. Identified item of non-compliance
    3. Any specified actions specifically required by the regulating body
    4. Specific action(s) the provider proposes to bring the item into compliance
    5. Specific goals(s) and/or outcome (s) the organization's addresses
    6. Date by which the action (s) will be completed
    7. Date by which the goal (s) and or outcome (s) will be attained
    8. Proposed documentation evidencing completion of the action (s) and
    9. Attainment of the goal(s)/outcome(s)

Policy 2.08 - Affirmative Action Plan

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to recruit, hire and promote qualified staff for all job classifications without regard to race, color, religion, sex, sexual orientation, language, age, spiritual beliefs, socioeconomic status, culture, national origin or handicap (the only exception being where sex or nature and degree of handicap is a bona fide consideration). In addition, all other personnel actions such as compensation, benefits, transfers, return from layoff, company sponsored training education, social and recreational programs will be consistent with and administered in accordance with the principals of equal employment opportunity.

It is our legal, moral, and social obligation that requires new goal settings programs with measurement factors assuring that affirmative action's share equal importance with our business goals. All management performance on the policy will be evaluated, as is performance on other company goals. Assertive Community Recovery will direct our employment and personnel practices toward ensuring truly equal opportunity for everyone, therefore, we intend that all matters related to recruiting, hiring, training, benefits, compensation, promotion or upgrading, transfer, social or recreational programs and all treatment on the job be free of discrimination practices.

ACR intends to measure itself against specific objectives that will continue to move our total employment posture aggressively towards full and equal participation of all staff in the opportunities available here. Periodic analysis will ensure that this policy is being successfully applied.

Policy 04.01 - Strategic Planning Policy and Procedure

A. It is the policy of Assertive Community Recovery, LLC (ACR) to utilize an ongoing strategic planning process to produce decisions and actions that guide and shape the organization in determining the ongoing relevancy of its mission, establishing strategic goals consistent with our consensual mission, and identifying specific strategies to meet the established goals.

B. Assertive Community Recovery, LLC (ACR)'s Strategic Plan is the result of a structured and disciplined administrative process guided by the CEO that utilizes the input of persons who are representative of the organization's stakeholders. The Strategic Plan represents the course our organization will take over a five-year period to meet the assessed external and internal environmental demands in a manner supportive of our financial, service delivery, and human resource stability and growth.

C. The Strategic Plan is a critical element of a comprehensive planning process within our organization. The components of organizational planning, and how they support the planning process are as follows:

1. Strategic Plan: The Strategic Plan represents the course our organization will take over a one to five-year period to meet the assessed external and internal environmental demands to support financial, service delivery, and human resource stability and growth.

2. Ongoing Work Plans: Ongoing work plans include goals, strategies, objectives, responsibilities, and timelines that are focused on specific areas of organizational functioning and typically contain short-term goals that can be met within a 12-month period. When goals on ongoing work plans require timelines that exceed one year, and/or require resources beyond the projected budgets of our organization, those goals may be noted simultaneously on our organizational strategic plan. Our organization's work plans are as follows:

    a. Accessibility Plan
    b. Cultural Diversity and Competency Plan
    c. Technology Plan
    d. Risk Management Plan
    e. Financial Plan/Budget

f. Performance Improvement Plan
g. Community Relations Plan (if applicable)
h. Diversion Plan (if applicable)

3. Analysis Documents: Analysis documents serve to assess, evaluate, and analyze the outcomes of organizational goals, actions, and processes, contained in organizational planning and performance improvement documents. The analysis documents represent processes that support the revision of strategic, work, and performance improvement plans. The organization's analysis documents are as follows:

    a. Annual Performance Analysis of Business and Service Delivery Functions (includes analysis of Strategic Plan progress and outcomes)
    b. Accessibility Status Report
    c. Annual Review of Formal Complaints
    d. Annual Critical Incident Analysis
    e. Annual Review or Audit of Financial Records
    f. Quarterly Budget and Expense Reviews
    g. Stakeholder Input Analysis Reports
    h. Management Team Meeting Minutes

D. The process of developing, actualizing, reviewing, and revising the Strategic Plan (described in the procedural section of our policy) will be based on taking advantage of the organization's strengths and opportunities while addressing our weaknesses and threats in the following areas:

1. The Expectations of the Persons Served
2. The Expectations of Other Stakeholders
3. The Competitive Environment
4. Financial Opportunities
5. Financial Threats
6. Organizational Capabilities
7. Social Determinants of Health

8. Community Demographics

9. Relationships with Stakeholders

10. The Regulatory Environment

11. The Legislative Environment

12. The use of technology to support
    a. Efficient Operations
    b. Effective Service Delivery
    c. Performance Improvement

13. Information from the analysis of performance

II. PROCEDURES:

A. Identification of Planning Participants: The participants and their key roles in Assertive Community Recovery, LLC (ACR)'s strategic planning process are as follows:

1. Leadership: Leadership Team

Leadership Role: Advocates for the strategic planning process and supports individual roles and responsibilities of those involved in the process. Identifies the members of the planning group and encourages participation. Seeks and identifies facilitator of planning process. Reviews plan drafts and analyzes for final approval. Responsible for final approval of plan and facilitates the communication of final plan within the organizational system. Has oversight of the monitoring and revision of plan, as needed, on an ongoing basis.

2. Planning Facilitator: TBA

Planning Facilitator Role: Facilitates the organization's strategic planning process in coordination with leadership.

3. Planning Group: Leadership Team, to include Certified Peer Specialist (CPS) who will advocate for the needs of consumers; and the Community Outreach Coordinator, who will be prepared to address the needs of community stakeholders; i.e. referral sources, housing providers, and caregivers.

Planning Group Role: Directly involved in the planning process of assessing the issues the organization faces and developing ideas and options for the future.

4. Plan Writer: Trese Harris, Quality Assurance/Director

Plan Writer Role: Assembles the planning group's process and resulting decisions into a functional document. Creates draft of the strategic plan based on notes of planning meetings.

5. Persons Served: The Certified Peer Specialist (CPS) will ensure that the needs of consumers are made known the Leadership Team during the strategic planning process. Consumers needs will be identified through the satisfaction, consumer surveys, Monthly Peer Center Advisory Board Meetings and consumer feedback during discharge from programs. The CPS will also share knowledge gain from active participation with the Georgia Consumer Network and Georgia Peer Specialist Project.

B. Strategic Planning Process:

The organization's strategic planning process is as follows:

1. Initiation of Planning Process:

    a. Strategic Plans will be updated every Five Year.
    b. Strategic Plans will be reviewed annually in August include changes/updates to Provider Manual and Letters of Agreement with the Department of Behavioral Health and Developmental Disorders.

2. Completion Target Date:

    a. The Leadership Team will determine a target date for completion of the planning process by identifying the date of a future meeting for adopting the plan.

3. Approval of Resources for Planning Process:

    a. Upon the recommendations of the Leadership, the CEO will consider approval of the following components of the planning process:

        1) Approval of recommended employee to serve as the strategic planning facilitator(s) and any associated training to support the employee.

        2) Approval of training site and logistical costs.

3) Approval of planning date(s) and the recommended participants for the organizational planning session.

4) Approval of costs associated with the training (training materials, food, etc).

4. Meeting with Facilitator:

   a. Prior to the organizational planning sessions, the designated strategic planning facilitator will meet with the management team to provide an overview of the planned strategic planning process and assess the overall organizational needs. The session will focus on gathering and presenting information in the following areas:

      1) Current issues that the organization is facing.

      2) An overview of the planning process, by the facilitator

      3) An assessment and discussion of any acute issues within organization's current operations.

      4) A discussion regarding the management team's expectations or expected outcome of the planning sessions.

5. Strategic Planning Process/Organizational Planning Session(s):

   a. Mission Statement Review: Facilitated process in which the full group of participants responds to questions, such as: What are we? Who are we? What do we do? What are the basic social, political, environmental, financial issues or problems the organization exists to address? What is the social/community justification for the organization to exist? How does the organization recognize, anticipate, and respond to the identified needs and problems? Who are the organization's key stakeholders and what do they want from the organization? What does the organization value? What makes the organization unique and gives it a competitive advantage?

   b. Organizational Regulatory Requirements and Mandates: Facilitated process in which the full group of participants respond to questions that address mandates, both formal (regulatory, no choice in meeting) and informal (expectations of clients or staff and how organization responds). Questions for facilitation of this process may include: What are we supposed to do and who requires us to do it? Responses are listed under formal or informal headings. After the brainstorming, individual participants rate the top three, in terms of importance (Techniques for this include providing each participant with three adhesive circle dots and instructing them to

place them by the top three requirements in terms of importance. Then a consensus can be identified by the top 4-5 rated items)

c. Mission Statement Gaps: A facilitated discussion to determine if the identified expectations are represented in the mission statement, and a listing of potential gaps.

d. Review of Past Outcomes: A facilitated process to determine what opportunities, threats, strengths, and weaknesses the organization has had to deal with over the past 5 years. The group is instructed to identify a list of positive and negative outcomes of the organization's operations for a specific range of years. (May go back five years. Through the separation into years, new employees can participate in the process by reviewing the past year first). Further instruction includes asking participants to identify themes in the generated lists of outcomes, and to identify antecedents that may have influenced the outcomes that are identified (loss of funding, change in leadership, etc). Large group discussion is facilitated to organize the responses into categories of Opportunities, Threats, Strengths, and Weaknesses (over the past 5 years) and, as they are being listed and identified, how each was dealt with by the organization.

e. A Vision of the Future: A facilitated process to develop what the organization will look like in 5 years. Participants are instructed to spend 5-10 minutes, in silence to imagine that they left the organization today and came back in five years to visit. After writing down their thoughts, the group leader solicits comments of the group, lists the comments, and combines common items, thus developing a master list. All participants are given three adhesive dots to place on the master list beside items they view as most important. The top 5 items become "high priority" for the planning phase of the process.

f. SWOT Analysis of Current Environment (Strengths, Weaknesses, Opportunities, Threats): A process whereby each SWOT component is identified and a brainstorming session of noting (writing a list) current issues related to the area is completed. All participants are given 12 adhesive dots and instructed to place a dot beside three items within each SWOT category on the posted lists. The top five items in each SWOT category are noted for the planning phase of the process.

g. Identification of Planning Themes: A process whereby the top 5 "Vision for the Future" items, the top 5 Strengths, and the top 5 Opportunities are listed in descending order. A large group process is facilitated whereby some or all of the following questions can be asked, and the identified themes can be revised accordingly:

1) Are all the themes consistent with the organization's mission? If not, should the mission be revised?

2) Are the themes consistent with each other? If not, have contradictions within the organization's operations and/or environment been missed?

3) Are the items distinct enough that they can be categorized (physical plant, services, personnel, etc.)? Are there interrelated themes among the items (need new programs/lack of physical space)?

4) Is there anything missing? Are the themes focused on immediate needs? Are the themes to global or general? How do the themes match up with the issues identified by the management team at the initial meeting with the facilitator?

5) Are the themes understandable to everyone? Did the process change an item to the point that the original meaning/intent has changed.

h. Identification of Action Steps and Time Frames: A facilitated process whereby each of the 15 identified themes (will probably be less due to combining common themes) are listed separately and the large group brainstorms anticipated major steps to achieve each one. All ideas are listed, regardless of possible differences. A separate sheet of paper is created for each of the next five years. Individual participants will identify the major steps under each theme, write it on a post-it note (use three colors of post it notes, one for each theme category) and will then place each note in the year they believe they think it will be completed. A facilitated process with the large group reviews notes posted within the years, reviewing themes and the sequencing of items. Questions asked include: Are the major steps in the correct order? Are completion dates realistic? What are the linkages between the themes? What are some of the identified weaknesses and threats that will affect the organization's ability to complete each step? What resources will be needed to accomplish each major component, and are they available or must they be acquired?

i. Identification of Goals/Themes and Objectives/Actions: Facilitator, with support from the previously identified plan writer, will list an overall set of goals and action oriented objectives and discuss with large group to clarify and revise according to group consensus.

6. Writing, Reviewing, and Adopting the Plan:

a. Writing a Draft of the Strategic Plan: At this stage, the plan writer will assemble the information into a format that communicates the key areas the planning sessions

identified, allowing the organization to move forward with implementing the plan. The draft of the plan will include these elements:

1) Mission of the Organization

2) The Organization's Mandates and Stakeholders

3) Summary of the SWOT Analysis

4) Vision of Future (Key items identified in the visioning exercise)

5) Strategic Issues, Goals, and Objectives

6) Financial Considerations

7) Timeline for Reviews and Updates

b. Review and Revision of Mission: A representative group of strategic planning participants (including the management team), led by the facilitator, will review the original mission statement, review the areas identified early that raised questions about the statement, review the planning themes, discuss linkages between the statement and planning themes, and identify possible areas of the statement that do not connect with the planning themes. Changes will be made by adding or deleting items from the mission statement and/or from the strategic issues. The process will continue until the mission statement accurately reflects the organization's current and future strategic goals.

c. Adopt the Plan: The management team will meet and review drafts of the plan and make a final recommendation for approval. The CEO/Ownership of the organization will be responsible for the approval any mission revision and the strategic plan.

7. Reviewing Plan Progress:

a. Progress Checks: The Leadership Team will review the plan's progress, and revise as needed, every three months.

Policy 05.01 - Plan for Input from Stakeholders

I. POLICY:

ACR is committed to actively seeking information from persons served, their families, employees, referral sources, funding sources, and other stakeholders, and committed to providing services in a manner that utilizes that information to ensure that the needs and preferences of all stakeholders are consistently met.

II. PROCEDURES:

A. The process of seeking and utilizing input from stakeholders contains the following basic components:

1. Obtaining input from persons served, their families, and other stakeholders on a regular basis.
2. Reviewing the input through all levels of administration and leadership.
3. Ensuring that our programs are "input driven" and reflect the needs and preferences of the persons we serve.
4. Using the input to change the practices and policies of the organization.
5. ACR is charged to review, revise, and develop an ongoing written input plan. This process includes developing additional methods to obtain and utilize input, ensuring that the information is being communicated to all stakeholders, and facilitating improvement of the practices of the organization.

B. **Plan:** The following is ACR's plan for input from persons served for the fiscal year 2022. In addition to ongoing processes that continue to be part of our plan, several new processes for input have been developed and are new within the organization for this fiscal year.

1. Peer Advisory Board:

The ACR's Peer Center Advisory Board conducts regularly scheduled monthly meetings. The Peer Center Advisory Board consist of Peer Center attendees and chaired by Certified Peer Specialist (CPS). The Peer Center Advisory Board serves as an advocate for all persons served. As a result of its activities, the chair of the board provides a monthly report to the management team that may include recommendations for the organization to consider in changing policy, procedures, and practices. These activities and the feedback

concerning changes are reflected in the management team minutes and are distributed to all employees of the organization and summarized in a monthly report to the board of directors.

2. **Suggestion Boxes:**

   ACR has a consumer suggestion box in a visible location. Suggestion forms and pencils are available at each suggestion box along with a sign that encourages feedback and suggestions. Each month suggestions are gathered by the Quality and Compliance Officer and shared with employees at that location in a regularly scheduled staff meeting for consideration of changes to assist in meeting the needs of persons served. Changes are made at the facility level if they involve daily activities and issues that are specific to that location that do not require organizational policy and procedural changes. All suggestions are submitted to the leadership team, and any suggestion that would require overall policy, procedure, or programming changes are considered by the leadership team who determine final disposition and actions. These activities and the feedback concerning changes are reflected in the leadership team minutes and are distributed to all employees of the organization.

3. **Staffing Conferences**

   ACR conducts weekly clinical staff meetings with all clinicians attending a meeting facilitated by their program director. These meetings include a consistent flow of information regarding communication between persons served and staff. Any specific information that would warrant further inquires or investigation are forwarded to the leadership team who utilize the information to modify, revise or change practices, policies, and procedures as a result of receiving the information. These activities and the feedback concerning changes are reflected in the leadership team minutes and are distributed to all employees of the organization.

4. **External Stakeholders Assessment and Input**

   ACR surveys a variety of external stakeholders to determine the level of satisfaction stakeholders have regarding the services of our organization. Formatted surveys are conducted with all referral sources. The surveys are conducted once a year and the results are reported to the leadership team as part of an annual summary report of performance improvement activities, recommendations and information. The leadership team makes recommendations based on the results.

5. **Employee Satisfaction Survey**

ACR conducts an internal employee satisfaction survey each year. The survey contains five domains that are reflective of the organization's work setting and employee's needs and preferences. Each domain contains multiple questions regarding employee satisfaction. The results are contained in a QI binder that is reviewed by the leadership team. Results are reviewed and recommendations for changes, based on the results, are reviewed for consideration. Results of the survey are additionally distributed to all employees.

Policy 06.01 - Confidential Information Dissemination

I. POLICY:

A. It is the policy of ACR Health Services to ensure that all verbal and written information of persons served is released in a manner that protects the individual's right to confidentiality. Information may not be released without the individual's written permission, except as the law permits or requires. ACR Health Services will make reasonable efforts to limit use, disclosure of, and requests for private health information to the minimum necessary to accomplish the intended purpose.

II. PROCEDURES:

A. Information may be released in written and/or verbal form. The release of information will occur upon receipt of an authorization determined as valid. Validity is determined by the presence of each of the following items:

1) The name of the person about whom information is to be released, including social security number.

2) The specific content of the information that is to be released.

3) The person to whom the information is to be released.

4) The signature of the person who is legally authorized to sign the release and the date on which the release is signed.

5) The expiration date of the authorization, not to exceed one year.

6) Information that defines how and when the authorization can be revoked.

B. Requests for Information:

1) All requests for information will be in writing.

2) Requests for information from an individual's record will be answered within seven (7) days from the date of receipt. If the information cannot be provided within this period, the requester will be informed in writing of

the reasons for the delay and the anticipated date the information will be available.

3) Requests for records that have been incorporated into ACR Health Services' records from outside sources will not be released and the requestor will be encouraged to seek those records from their original source.

C. Release of Sensitive Information:

1) Information contained within the individual records may have a serious adverse effect on an individual's mental or physical health if disclosed to the individual. Such information may contain materials requiring an explanation or interpretation to assist in its acceptance and/or assimilation in order to avoid an adverse impact on the individual's health. To minimize the risk of a release of information adversely impacting a person served, the following guidelines will apply:

a. The Clinical Director will review all requests of individuals seeking direct access to their records. Information identified as potentially sensitive will be reviewed by Clinical Director. This review will occur within one working day of the referral.

b. All materials directly related to behavioral health treatment that includes a diagnosis, assessment, or interpretative data will be reviewed by Clinical Director.

c. If after the professional review of the record, it is believed that disclosure of the information directly to the individual could have an adverse effect on that individual, arrangements will be made to disclose the information to a professional staff member selected by the individual. The staff member will discuss the information with the individual prior to the release.

d. Should it be determined by the professional staff member that after a careful and conscientious explanation of the information to the individual has been made, and it is the opinion that access to the information could be harmful, physical access will be denied. The justification for making the denial will be fully documented by the staff member and final concurrence will be made by Medical Director. The individual will be advised of the

denial, the reasons for the denial of the request, and advised of the right to file a grievance, should the individual disagree with the decision.

D. ACR Health Services legal counsel will be consulted when the release of information involves the following circumstances:

1) Any request for records that are to be used in a suit against the organization or in a prosecution against a person served.

2) All subpoenas for records that were not accompanied by a written consent signed by the person served.

3) All requests for information which indicates a possible liability for the cost of care and services.

E. Information may be released without the consent of persons served under the following conditions:

1) For use by any ACR Health Services employee who has a need for the information in the performance of their duties to ensure continuity of care.

2) To medical personnel who have a need for the information for the purpose of treating a condition which poses an immediate threat to the health of a person served.

3) To public health authorities related to infection with HIV when there is a written request that the information and there is a fine or penalty for failure to comply.

4) To a spouse or sexual partner of an individual when it is reasonably believed that the individual will not provide disclosure of information related to infection with HIV when that information is necessary to protect the health of the spouse or sexual partner.

5) To recover or collect the costs of medical care from third party health care insurance carriers contracted with by the persons served and required by the health plan to be disclosed.

6) To Federal, State, or local government agencies or entities charged under applicable laws with the protection of public health and safety. In such cases, the information may be released with the consent of the individual

whose records are being requested, or upon receipt of a written request from the head of the government entity. A request for release under these circumstances may be either a standing written requested based on reporting requirements, or a specific written request from the head of a law enforcement agency for a special law enforcement purpose. Standing requests must be updated in writing every year.

7) Disclosure as a result of a court order from a court of competent jurisdiction.

8) To the Department of Children and Family Services for the purpose of investigating abuse, neglect or exploitation.

9) To the Medical Examiner, in conjunction with an investigation of a suspicious death.

10) To professional review organizations, in accordance with government contracts (Medicare/Medicaid).

11) Disclosure of information to a third-party payer in a care cost recovery action will be limited to date of birth; social security number; payment history; and account number, unless the individual provides a written consent designating further information to be released.

F. An accounting record will be maintained on all records released by ACR Health Services. It will include the date, nature and purpose of each disclosure, the name of the party to whom the disclosure is made. This accounting record will be maintained in the record from which the disclosure was made. In addition, a logbook will be maintained for all release of information for data reporting purposes.

G. Special consent is required to release records that contain information related to drug and alcohol addiction and abuse, and tests for, or infection with human immune virus. Any authorized disclosure from records containing information of this type will be limited to that information which is necessary for the purpose of the disclosure. Because of the special nature of this information, the release must be processed by Director of Quality and Compliance to assure compliance with the special regulatory requirements.

H. The following type of communications do not constitute disclosure of information/records:

1) Communication of information between any ACR Health Services employees who have a need for the information in connection with their official duties.

2) Communications with law enforcement offices which are directly related to the person served committing or threatening to commit a crime on the organization's property or against an employee of the organization.

3) Communication of information which does not provide an individual's identifying information.

I. ACR Health Services will protect the confidentiality of private health care information when transferring data electronically by adherence to the following guidelines:

1) All data sets containing individual names transferred on a diskette, e-mail or any other electronic medium, will be password encrypted.

2) The sending and receiving parties prior to transfer of the electronic data will negotiate passwords.

3) Passwords will be at least eight characters in length, contain both letters and numbers, and must not be commonly used words.

4) Passwords for encrypted files may not be mailed in the same shipping package as the encrypted file.

J. ACR Health Services will adhere to the following guidelines when mailing confidential private health information:

1) Stamp all envelopes containing records as confidential.

2) Clearly indicate a particular office on the address where the envelope is to be delivered.

3) Whenever possible, include in the address the name of the staff member authorized to open the envelope.

4) All envelopes individually addressed will contain the following statement in the outside of the envelope: "TO BE OPENED BY ADDRESSEE ONLY".

K. When faxing confidential information, the following guidelines will apply:

1) Confidential private health information will only be transmitted by fax when absolutely necessary or required by the requestor, and other traditional methods such as confidential mail is not possible to deliver the information.

2) All fax cover pages for confidential information will contain the following:

    a. The name and program of the person to whom the fax is intended.

    b. The name, program, and phone number of the person sending the fax.

    c. The statement “Confidential Information” in a large bold font.

    d. A statement that clearly identifies the accompanying material as confidential information that reads as follows: “*The documents accompanying this facsimile transmission contain confidential information which is legally privileged. The information is intended only for the use of the recipient named above. If you have received this facsimile in error, please immediately notify us by telephone to arrange for return of the documents to us, and that you are hereby notified that and disclosure, copying, distribution or the taking of any action in reliance on the contents of this facsimile information is strictly prohibited.”*

3) In situations where the information is not being regularly faxed to a common organization and individual, a phone call will be made to the person receiving the fax to verify the fax number and a follow-up call will be made to ensure the receipt of the fax.

4) Fax transmissions will be restricted to persons specifically authorized to transmit confidential information.

5) Fax machines will not be situated in common public areas.

6) Fax number lists will be current, accurate, and regularly checked.

7) All transmission records will be checked to detect possible transmission errors and retained for confirmation purposes.

8) Upon the receipt of any confidential misdirected fax, the sender will be contacted and the information will be shredded.

9) When the fax machine is unattended at night or on weekends, the print memory will be activated to prevent printing of confidential information when staff are not present.

10) When a fax server is used in lieu of a machine, password protocols will be in place that will restrict and define user access.

L. Any information released verbally over the phone, can only be done after verification of the caller's identity through taking the phone number and making a call back prior to releasing the information.

M. All telephone calls from outside the organization that request confirmation of an individual being served by ACR Health Services, will be handled by repeating the following statement: "*I can neither confirm or deny that the individual in question is receiving services or has ever received services without a written authorization from that individual."*

N. Any ACR Health Services employee who knowingly and/or willfully violates provisions of this policy and procedures will face administrative disciplinary action that may result in termination of employment.

Policy 07.01 – Annual Budget Process

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to develop an annual budget that ensures resources are being appropriately allocated for the mission, goals, and objectives of the organization to be met.

II. PROCEDURES:

A. The CEO/Executive Director will provide all Program Managers with revenue and expense worksheets three months prior to the new fiscal year.

B. The Program Managers will provide monthly estimates of revenue by payer source and any anticipated increases or decreases in operating expenses within their program areas to the CEO/Executive Director.

C. The Program Managers will work in cooperation with the appropriate administrative personnel in providing an estimate of revenue by payer source.

D. The Program Managers will provide any anticipated increases or decreases in expenses within their areas of operation. The Human Resource Director will be responsible for salaries and fringe benefits of personnel in all programs and departments.

E. All reports will contain a brief justification for any budget increases of over 10% from the previous year in any operating category.

F. The estimates of revenue and expenses are due two weeks after the worksheets are distributed.

G. The Clinical Director will submit to the CEO/Executive Director proposals for spending increases and decreases based on the Assertive Community Recovery strategic plan.

H. The CEO/Executive Director will compile the results of all submissions and develop a draft of the budget for the next fiscal year.

I. The draft budget will be presented to the management team no later than two months prior to the beginning or the next fiscal year for review, feedback, and revision.

J. The CEO/Executive Director will make the final adjustments following the review, feedback, and revisions and will approve the final budget proposal.

K. Following final approval, the final budget for the fiscal year will be distributed to Program Managers to ensure an organization-wide awareness of the financial plan for the next fiscal year.

Policy 07.02 – Annual External Financial Audit/Review

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to complete an annual review by an independent organization to ensure that business is conducted consistent with sound fiscal practices, and to utilize the results of the review to improve the financial condition of the organization.

II. PROCEDURES:

A. The CEO/Executive Director is responsible for ensuring that an annual review is arranged, completed, and the results are received.

B. The CEO/Executive Director will contract with a local accounting firm annually to conduct an review of the organization's fiscal practices, books, and records.

C. The CEO/Executive Director will facilitate the onsite review and organization of records needed to ensure a successful review.

D. The CEO/Executive Director will receive a written report from the accounting firm, will review the report and act on any recommendations to correct and/or enhance business practices.

E. The CEO/Executive Director will additionally distribute report recommendations of the review to the Executive Team is deemed appropriate to facilitate improvements/enhancements in organizational business practices. Feedback and suggestions will be sought from the Executive Team to assist in the enhancement of business practices.

F. The actions taken to enhance business practices and the results of those actions will be documented and reported in the Executive Team meeting minutes.

Policy 07.03 – Accountability for Department of Behavioral Health and Developmental Disabilities (DBHDD) Units of Service

I. POLICY:

To acknowledge the method used to account for units of billable service when providing mental health and substance abuse services.

II. PROCEDURES:

A. In the progress note staff will record units of service and/or time of service.

1. Staff will record the actual times that clients services begin and end e.g. 10:00 to 10:14. ACR will not use "block time."
2. Progress Notes: Staff will record the number of units of service provided, in the example above the staff member will record the appropriate unit of service as outlined for the service provided in the most recent Department of Behavioral Health and Developmental Disabilities (DBHDD) Providers Manual. Please note that there are several services that are billed by "encounter" instead of by time. Staff will record the times that client services begin and end in the body of the progress note.

B. Clinic/Screening, Crisis and Outreach Services are billed

1. **in 15-minute units**. Determine the number of unit(s) of service by rounding down to up to the nearest unit (7 minutes and lower round down; 8 minutes and above round up). Examples follow below:

0 to 7 min	0 units
8 to 22 min	1 units
23 to 37 min	2 units
38 to 52 min	3 units
53 min to I hour - 7 min	4 units
I hour - 8 to I hour - 22 min	5 units
I hour 23 min to I hour - 37 min	6 units
I hour 38 min to I hour - 52 min	7 units
I hour - 52 min to 2 hours -7 min	8 units
and so on…..	

C. Services for clients that are funded through DFACS cannot be billed to Medicaid.

Policy 07.04 - Cash Control and Flow

I. POLICY:

It is the policy of ACR to maintain active controls on the receipt of revenues and to ensure that revenues are deposited to appropriate budget cost center accounts.

II. PROCEDURES:

The CEO is responsible for maintaining procedures for the security of revenues generated by ACR. Revenues will be secured through the following methods:

a. All incoming revenue by mail from third parties (insurance providers, state agencies, and donations) is logged into the accounting data system by accounting personnel/CEO.

b. All incoming checks or cash obtained by clinicians are receipted and logged by accounting personnel/CEO, delivered to accounts receivable, entered, and deposited daily.

c. All checks are duplicated for the accounting files.

d. The CEO or designee deposits any revenues received into the organization's bank account on a daily basis.

e. Monies received for Medicaid or Medicare services are transferred electronically directly from the source into the organizations bank account.

f. The Corporate Compliance Policy, specifically the procedures on monitoring and auditing will serve as the organization's oversight in the area of fraud. Procedures will ensure that monitoring and auditing practices are being conducted on an ongoing basis in critical areas of the organization's operation to maintain compliance with all laws and guidelines governing the organization. Internal self-audits will include, but not be limited to, fiscal services (billing and coding), marketing, contractual services, health and safety practices, use of agency resources, confidentiality, dual relationships, and medical necessity.

Policy 07.05 – Working Capital and Contingency Funds

I. POLICY:

A. It is the policy of Assertive Community Recovery, LLC (ACR) to maintain active controls on the receipt of revenues and to ensure that revenues are deposited to appropriate budget cost center accounts to maintain adequate working capital and contingency funds through specific fiscal mechanisms and practices that will ensure the continuation of services without interruption.

II. PROCEDURES:

A. The CEO/Executive Director is responsible for maintaining procedures for the security of revenues generated by ACR.

B. The CEO/Executive Director is responsible for the fiscal planning functions that ensure services are provided without interruption.

C. The CEO/Executive Director will create cash flow projections monthly to ensure that adequate funds are being received and that lines of credit are not being exceeded.

D. The CEO/Executive Director will utilize the cash flow projection information to adjust payments as required to ensure cash is available for operations.

E. The CEO/Executive Director shall determine the need for a line of credit to be available on demand to assist with cash flow when needed; if it is determined that a line of credit is needed then the CEO/Executive Director contact financial intuitions to arrange for an adequate Line of Credit.

F. The organization will utilize the financial planning process, which includes an annual budget to ensure minimal reliance on lines of credit.

G. The organization will maintain a contingency fund based on the ratio of one-third of the operating funds for a three-month period.

H. Financial planning of expenditures is done on a weekly and monthly basis with long-range cash flow projection to maximize funds.

Policy 07.06 – Inventory of Capital Equipment

I. POLICY:

A. It is the policy of Assertive Community Recovery, LLC (ACR) to ensure that the assets of the organization are accounted for and are available for use through minimizing risks of misuse, damage, theft, or loss. An inventory of assets will be maintained for the purposes of calculating depreciation, tracking and security, and loss reporting for insurance.

II. PROCEDURES:

A. A capitalized asset will be defined as a product purchased having a useful life of greater than one year and having a cost of greater than $1,000.00.

B. Accountability will be required of those individuals empowered with the authority to decide as to the acquisition, employment, and disposition of the asset. Should documentation be absent regarding the assignment of accountability of an asset to a specific individual, accountability shall rest with the program or unit supervisor whose budget account paid for the asset, or program or unit supervisor who received equipment through donations or transfer.

C. Capital Equipment Inventory: ACR will maintain a capital equipment inventory list for the purposes of tracking and security, calculating depreciation, and loss reporting for insurance.

D. All items valued at over $1,000.00 will be recorded in the capital equipment inventory by item and location, and charged as “equipment” in the general ledger. Items with a cost of over $1,00.00 will be given a control tag, recorded in the inventory by item and location, and charged as a “fixed asset” in the general ledger.

   1) The capital equipment inventory will designate all items by account, e.g., the corresponding site where the item is located and the fiscal account of that entity.

   2) Programs or service sites receiving equipment are responsible for notifying the Director of Administration when the equipment arrives.

   3) The Director of Administration will be responsible for recording all purchases in the inventory at the time payment is made.

4) All staff members are responsible to coordinate disposal of capital equipment with the Director of Administration. The Director of Administration r) is responsible for to remove the asset from the inventory. Items will be marked as “disposed,” with a date and method of disposition. The item will continue to have a value recorded on the inventory, until the end of the fiscal year of the disposal. The value of the item will then be removed from the inventory records, but all other information will be retained for a period of five years from the date of disposal.
5) The Director of Administration will be responsible to conduct a physical fixed asset inventory every other year, in even years. Items will be marked as “missing” and “found,” as appropriate, at the time of the inventory and updated in the inventory.

E. Each site is responsible for any and all equipment reflected on the official inventory report that is charged to their account. The site sponsor will be responsible for equipment as follows:
    1) Accepting and signing the official inventory report upon each physical count.
    2) Notification of any change as outlined in the above policy.
    3) Notification to the proper party of any equipment that is lost, damaged, or stolen.
    4) Making available all items of equipment for the purpose of physical inspection.

Policy 07.08 - Accurate Billing

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to ensure that sure that all billing are accurate and in compliance with applicable guidelines and procedures.

II. PROCEDURES:

A. Billing is performed daily.

B. Census report is given to the administrative assistant/intake coordinator who files it in the census book located in the records department

C. Billing Manager/Designee prepares the billing activity log and calculates the number of units provided per client.

D. Billing Manager/Designee submits unit claims electronically to Medicaid.

E. Individual sessions, medication management, nursing assessments and psychiatric evaluations are submitted electronically to Medicaid.

F. When submitting claims the Billing Manager will double check unit participation list, super bills and census log to ensure accuracy of claims.

G. To prevent, Duplicate Billing ACR staff will not submit claims to more than one primary payer at the same time. All claims submitted will be doubled checked by the Billing Manager/Designee and a log will be maintained as to what primary payer was billed.

H. Billing Reconciliation is conducted at least monthly; when errors are identified either plus or minus, steps are taken to correct the error through the payer's billing service.

Policy 07.09 - Internal Control System

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to ensure that ACR staff will follow sound accounting procedures and that all accounting procedures are governed by the appropriate personnel.

II. PROCEDURES:

A. Access to financial records is limited to the CEO/designated employees, designated ACR employees or such employees for designated responsibility for such records.

B. Upon receipt of a check, a restrictive endorsement is to be stamped.

C. All disbursements made by check are under the supervision of the CEO/Designee. There are no checks payable to "cash."

D. All blank checks are under the control of the CEO/Designee. Only the CEO or her designated employees will access check stock.

E. The signature plate is under the control of the CEO or her designee and kept under control at all times.

F. The CEO or her designee only will draw checks on the bank accounts of the Agency or the Representative Payee accounts.

G. Voided checks are marked "void" and the signature panel removed from the check.

H. The CEO or her designee will prepare monthly bank reconciliations for all Agency accounts.

Policy 07.10 - Providing and Documenting for Billable Services

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to ensure that ACR staff who provide MH/AD billable services will be knowledgeable of the service definitions, program descriptions and limitations of the services that are being provided and subsequently billed to Medicaid, Medicare and other funding sources.

II. PROCEDURES:

A. All ACR staff that provides MH/AD billable services is provided access to a reference copy of the Provider Manuals for Georgia DBHDD Community Providers, Care Management Organizations (CMO), Department of Family and Children Services (DFCS) and for any other payer organizations.

B. Internal and external audits are conducted on a routine scheduled basis to assess ACR compliance with policies and procedures addressed in the payer provider manuals.

C. It is expected that ACR will receive on site reviews and audit conducted by the various payer organizations that fund the services that ACR provides. The results of reviews/audits are given to ACR in oral and written formats. ACR develops a written plan of compliance to address deficiencies.

D. The Compliance/Quality Assurance Program Manager conducts reviews/audits of clinical and billing documentation to assist program services managers by identifying and/or analyzing individual staff or program-wide performance deficits.

E. ACR staff shall be trained on providing and documenting billable services.

   1) During orientation for new staff who will provide billable services.
   2) During Committee meetings for Program Managers
   3) During team meetings for professional and paraprofessional staff.
   4) During required supervision meetings for all staff.

Policy 07.11 - Sliding Fee Discount Application

It is the policy of ACR Health Services, Inc., to provide essential services regardless of the individual's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at ACR, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. Must completed the Request for Discounted Services form every 12 months or if your financial situation changes (See Attached form).

Sliding Fee Discount Program

Purpose: To make available discount services to those in need.

This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). In addition to quality healthcare, individuals are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full. ACR will refer individuals to agencies that may assist individuals in finding reasonable payment alternatives.

ACR HEALTH SERVICES will offer a Sliding Fee Discount Program to all who are unable to pay for their services. ACR HEALTH SERVICES CLINIC will base program eligibility on a person's ability to pay and will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

PROCEDURE: The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification:** ACR HEALTH SERVICES will notify individuals of the Sliding Fee Discount Program by:
    - Payment Policy Brochure will be available to all uninsured individuals at the time of service.
    - Notification of the Sliding Fee Discount Program will be offered to each individual upon admission.
    - Sliding Fee Discount Program application will be included with collection notices sent out by ACR HEALTH SERVICES's
    - An explanation of our Sliding Fee Discount Program and our application form are available on ACR HEALTH SERVICES's website.
    - ACR HEALTH SERVICES places notification of Sliding Fee Discount Program in the clinic waiting area.

3. All individuals seeking healthcare services at ACR HEALTH SERVICES are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**
4. **Request for discount:** Requests for discounted services may be made by individuals, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk and the Business Office.
5. **Administration:** The Sliding Fee Discount Program procedure will be administered through the Business Office Manager or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided charitable services.
6. **Alternative payment sources:** All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs.
7. **Completion of Application:** The individual/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize ACR HEALTH SERVICES access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

   If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a individual does not provide the requested information within the two week time period, their application will be re-dated to the date on which they supply the requested information. Any accounts turned over for collection as a result of the individual's delay in providing information will not be considered for the Sliding Fee Discount Program.

8. **Eligibility:** Discounts will be based on income and family size only. ACR HEALTH SERVICES uses the Census Bureau definitions of each.
    1. **Family** is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
    2. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.*

8. **Income verification:** Applicants must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine

eligibility for the program. **Self- declaration of Income** may only be used in special circumstances. Specific examples include participants who are homeless. Individuals who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to ACR HEALTH SERVICES's CEO or his/her designee for review and final determination as to the sliding fee percentage. Self-declared individuals will be responsible for 100% of their charges until management determines the appropriate category.

9. **Discounts:** Those with incomes at or below 100% of poverty will receive a full 100% discount. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines, http://aspe.hhs.gov/poverty.

10. **Nominal Fee:** Individuals receiving a full discount will be assessed a $10 nominal charge per visit. However, individuals will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

11. **Waiving of Charges:** In certain situations, individuals may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by ACR HEALTH SERVICES's CEO, CFO, or their designee. Any waiving of charges should be documented in the individual's file along with an explanation (e.g., ability to pay, good will, health promotion event).

12. **Applicant notification:** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the individual and/or responsible party must immediately establish payment arrangements with ACR HEALTH SERVICES. Sliding Fee Discount Program applications cover outstanding individual balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

13. **Refusal to Pay:** If an individual verbally expresses an unwillingness to pay or vacates the premises without paying for services, the individual will be contacted in writing regarding their payment obligations. If the individual is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the individual does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, ACR HEALTH SERVICES can explore options not limited, but including offering the individual a payment plan, waiving of charges, or referring the individual collections efforts.

14. **Record keeping:** Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Business Office Manager's Office, in an effort to preserve the dignity of those receiving free or discounted care.

1. Applicants that have been approved for the Sliding Fee Discount Program will be logged in a password protected document on ACR HEALTH SERVICES shared directory, noting names of applicants, dates of coverage and percentage of coverage.
2. The Business Office Manager will maintain an additional monthly log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials will also be logged.

15. **Policy and procedure review:** Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the CEO. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices that may serve as barriers preventing eligible individuals from having access to our community care provisions.

16. **Budget:** During the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed into the budget as a deduction from revenue. CEO approval for Sliding Fee Discount Program will be sought as an integral part of the annual budget.

ATTACHMENTS:
Individual Application for the Sliding Fee Discount Program

Appendix D: Sample Public Notice Signage

NHSC-approved sites are required to inform individuals of the sliding fee discount program. The following examples illustrate language to be posted prominently online and at the physical site. NHSC encourages sites to establish multiple methods of informing individuals.

Public Notice Signage Example One

NOTICE TO INDIVIDUALS:

This practice serves all individuals regardless of inability to pay. Discounts for essential services are offered based on family size and income. For more information, ask at the front desk or visit our website. Thank you.

AVISO PARA PACIENTES:

Esta práctica sirve a todos los pacientes, independientemente de la incapacidad de pago. Descuentos para los servicios esenciales son ofrecidos dependiendo de tamaño de la familia y de los ingresos. Usted puede solicitar un descuento en la recepción o visita nuestro sitio web. Gracias.

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)												
Poverty Level*	**100%**	**110%**	**120%**	**130%**	**140%**	**150%**	**160%**	**170%**	**180%**	**190%**	**200%**	**>200%**
Family Size	**DISCOUNT**											
	100%	**100%**	**90%**	**80%**	**70%**	**60%**	**50%**	**40%**	**30%**	**20%**	**10%**	**0%**
1	$11,880	$13,068	$14,256	$15,444	$16,632	$17,820	$19,008	$20,196	$21,384	$22,572	$23,760	$23,761
2	$16,020	$17,622	$19,224	$20,826	$22,428	$24,030	$25,632	$27,234	$28,836	$30,438	$32,040	$32,041
3	$20,160	$22,176	$24,192	$26,208	$28,224	$30,240	$32,256	$34,272	$36,288	$38,304	$40,320	$40,321
4	$24,300	$26,730	$29,160	$31,590	$34,020	$36,450	$38,880	$41,310	$43,740	$46,170	$48,600	$48,601
5	$28,440	$31,284	$34,128	$36,972	$39,816	$42,660	$45,504	$48,348	$51,192	$54,036	$56,880	$56,881
6	$32,580	$35,838	$39,096	$42,354	$45,612	$48,870	$52,128	$55,386	$58,644	$61,902	$65,160	$65,161
7	$36,730	$40,403	$44,076	$47,749	$51,422	$55,095	$58,768	$62,441	$66,114	$69,787	$73,460	$73,461

8	$40,890	$44,979	$49,068	$53,157	$57,246	$61,335	$65,424	$69,513	$73,602	$77,691	$81,780	$81,781
For each additional person, add	$4,160	$4,576	$4,992	$5,408	$5,824	$6,240	$6,656	$7,072	$7,488	$7,904	$8,320	$8,320

Policy 8.03 - Media Relations

It is the policy of ACR Health Services to respond to news media effectively, accurately and in a timely manner. This policy will help to promote public understanding of the services, and activities of this organization. Effective communications with the news media shall be implemented responsively.

ACR Health Services is committed to open communication about our mission, programs, services, values and policies surrounding the organization's role in serving our clients.

Information about specific cases, clients, circumstances and families is governed according to federal and state statutes on personal privacy and confidentiality. The ACR and staff will work cooperatively in both responding to inquiries to increase public understanding and knowledge of services provided.

The identified employee(s) with the authorization to speak with or provide any written documentation (i.e. press release) to media shall be the Executive Director. In the event media requests to speak with a staff person about a client, case, circumstance, etc., please direct the media representative to the Executive Director. If this request is received after hours, please direct the media representative to contact the Executive Director.

In preparing responses, the Executive Director consults, as appropriate, executives and staff members; and keeps the CEO informed of ongoing inquiries, as appropriate. The Executive Director coordinates, monitors and provides assistance regarding media inquiries and decides the course of action about responses when warranted. The Executive Director summarizes media contacts in regular written reports to the CEO.

Staff may not acknowledge whether or not someone has ever been a client of the organization.

Photography, audio or video recordings, or any other type of recording device that could be used to document the identity of anyone visiting or being treated at ACR is forbidden. This applies to members of the press as well as anyone else, including staff, clients, and family members and/or friends of clients/staff.

Policy 8.04 - Social Media Policy (for all employees)

ACR Health Services may provide social media venues that encourage collaboration with staff members, clients, vendors, and other industry professionals. The primary goal of these venues is an interactive exchange of ideas in the pursuit of professional and personal development. Other social media may include personal blogs, Facebook, LinkedIn, MySpace, Twitter, YouTube and others. It is important that the following policies are adhered to:

1. No confidential information may be shared at any time. This includes private information with regard to clients, co-workers or other business associates. Providing any information about clients is illegal, even if a client's friends or family members online have already disclosed the information.

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2. Staff members should identify themselves by name and, when relevant, title. Staff members must make clear they are representing their own views and not that of ACR Health Services. The following disclaimer may be used:
"I am an employee of ACR Health Services. The statements or opinions expressed are my own and do not necessarily represent those of ACR Health Services.

3. Individuals creating a website or blog that will mention our organization are required to receive authorization from their manager.

4. ACR Health Services sites may not be used to endorse any outside person, product, service or organization. External links may only be used with the permission of Executive Director or CEO.

5. If an employee's affiliation with ACR Health Services on a social media website is known, (such as LinkedIn) the conduct must be consistent with the professional standards of ACR Health Services. External endorsements should not be given or requested.

6. Discriminatory, harassing, intimidating, or offensive language is not consistent with the policies of ACR Health Services. All communication must be free from harassment regarding racial, ethnic, religious, physical, gender, sexual orientation or any other protected classification.

7. Proprietary or confidential company information may not be shared. This includes revenue, business performance, future plans, employee compensation, or share prices.

8. ACR Health Services logos, trademarks or proprietary graphics may only be used with the expressed consent of ACR Health Services.

Policy 09.01 - Emergency Information Dissemination

POLICY:

A. It is the policy of to ensure that persons served, staff members, and visitors are aware of information to assist them in responding to emergency preparedness and situations that may occur on the premises of ACR administrative and service delivery facilities.

PROCEDURES:

A. The CEO is responsible for the oversight of emergency information dissemination, planning, and evaluation of the effectiveness of the information.

B. The site managers will receive bi-annual emergency disaster training at Health and Safety Committee meetings to ensure each facility has representation that is fully informed and up to date on all emergency policies and procedures.

C. Emergency information plans, and practices will be clearly communicated within the organization's employee orientation process and will contain the following components:

    1) A comprehensive review of the Emergency Drill and Disaster Policy and Procedure, with evidence of the staff members understanding of their role and responsibilities in the procedures.

    2) A comprehensive review of all related health and safety policies and procedures.

D. Program Participant Emergency Plan Education:

    1) All persons served will be orientated and informed of ACR emergency plans upon entry into the program as part of their orientation.

    2) All persons served will participate in emergency drills at the facility locations and will be oriented to facility safety at each location in which they are involved in services.

E. Posting of Emergency Plans:

1) The location of exits, first aid kits, and fire extinguishers shall be clearly posted at all locations.

2) Emergency exit plans will be adequate in number and specific to the location of the posting.

3) Emergency exit plans will include both diagrams and written instructions.

4) Emergency exit plans will indicate the safest and quickest way out of the facility and to the “Severe Weather Safe Place.”

5) Emergency exit plans will indicate the location of the fire extinguishers and the first aid kit.

6) All of the above requirements will be checked for compliance during the bi-monthly self-inspection of the site.

Policy 09.02 - Risk Reduction and Critical Incident Reporting

I. POLICY:

A. It is the policy of Assertive Community Recovery (ACR) to provide prompt and complete responses to persons served, staff members, and visitors needs in situations containing risk of injury; to call attention to physical situations that need to be investigated or resolved to ensure a safe environment for patients, staff members, and visitors; to determine issues that can be addressed for enhancement or improvement through management and planning; and to manage risk of situations with potential liability for the organization. Incidents, of a serious nature, that compromise the health and safety of persons served by ACR, its staff members, and visitors, will be documented and reviewed for the purpose of decreasing the likelihood of similar future incidents.

B. Critical incidents shall be defined to include any situation, action, or result of an action that is not consistent with the routine care of a person served, routine services provided by the organization, the routine operation of the organization, or the safety and security of environments in which services are provided.

C. It is the policy of ACR that all situations, behaviors, and/or actions meeting the criteria for a reportable incident are documented and forwarded to the appropriate staff for further investigation and management, as per the procedures contained in this policy.

D. ACR Leadership must be knowledgeable of and follow the DDHDD's Policy 04-106 - Reporting Deaths and Critical Incidents in Community Services. DBHDD policies are located on the internet at https://gadbhdd.policystat.com

II. PROCEDURES:

A. Responsibility for the reporting and management of critical incidents are as follows:

1) The Chief Executive Officer, CEO is the legal entity charged with the responsibility of health and safety management for the organization and within this role ensures that critical incident issues that affect the overall stability and continuing operation of the organization are being reported, reviewed, and managed within the overall structure of the organization.

2) The Quality and Compliance Officer is responsible for overall organizational oversight in the area of critical incident reporting and management, and reviews all incidents by investigating and determining causes and trends, determining legal liability and insurance issues, and recommending policy and procedure changes based on the comprehensive reviews.

3) The Safety Officer is responsible for the day-to-day oversight and functioning of the critical incident reporting system. Specific responsibilities include:

    a. Interview persons involved in the incidents, or who were witness to the incidents, to assist in developing conclusions and recommendations.

    b. Providing and managing information regarding outside legal entities should an incident require such action.

    c. Acting as the point of contact for all supervisory personnel when a critical incident occurs within the organization.

    d. Advising the Quality/Compliance Officer and CEO about incidents of a severe nature that acutely threaten the therapeutic milieu of the organization and result in a death, serious injury, alleged abuse, neglect, or exploitation of a patient, staff member, or visitor.

    e. Providing monthly reports to the Quality and Compliance Officer that assist in evaluation and management of the organization's practices and environment.

4) The Executive Director is responsible for serving as the organization's point of contact, for all critical incidents involving employees. Responsibilities in this area include:

    a. Serving as the liaison with the employee and outside entities in areas such as health insurance, worker's compensation, and return-to-work issues.

b. Ensuring that all legal and regulatory requirements are being addressed in the area of employment practices and staff involvement in a critical incident.

5) The Safety Officer(s) in their role as the overall coordinator of the facilities' health and safety program is responsible for any immediate response to a critical incident by ensuring that all health and safety policy and procedures are followed immediately after a critical incident has occurred.

6) All ACR staff members are responsible for promptly reporting any incident that fits within the reporting guidelines for a critical incident. To support this process, staff members are expected to be knowledgeable with all organizational policy, procedures, and practices in the area of critical incident reporting.

B. The criteria for completing a critical incident report is as follows:

1) Injury or potential injury to an individual served by ACR on its property or a sponsored event or at any location when ACR staff is present

2) Injury or potential injury to a staff member of ACR while conducting business for ACR.

3) Injury of potential injury to any individual on ACR property.

4) Any event that may have potential liability for ACR.

5) Deaths.

6) Medical emergencies to include communicable disease or infection control incidents.

7) Use or seclusion or restraint (Although seclusion or restraint is not allowed by ACR Policy any use of most be reported as a critical incident)

8) Medication errors.

9) Alleged physical, psychological, or sexual abuse.

10) Alleged neglect.

11) Self-abuse by a person served.

12) Alleged exploitation and/or harassment.

13) Assaultive behavior, aggression or violence.

14) Alleged criminal activity.

15) Restraint of any person served, employee, or visitor.

16) Vehicular accident in the performance of duties.

17) Physician's order errors.

18) Fires, natural disasters, bomb threats, and power failures.

19) Property damage/theft including ACR property and personal property.

20) Incidents that have the potential for public access to information that may discredit ACR or compromise confidentiality.

21) Unauthorized use or possession of licit or illicit substances.

22) Use and unauthorized possession of weapons

23) Elopement and wandering.

24) Biohazardous accidents.

25) Unauthorized use and possession of legal or illegal substances.

26) Suicide and attempted suicide.

27) Sexual Assault

28) Overdose

29) Other sentinel events or incidents as designated by DHBDD

C. Critical incidents will be responded to and reported in the following manner:

1) First, manage the incident according to all health and safety policies, procedures and plans.

2) The following events require local authorities to be notified within 15 minutes of the discovery of the event:

    a. The death of anyone on the organization's property by any means.

    b. Physical or sexual assaults involving persons served, employees or visitors, determined to be a reportable law violation.

    c. A suicide attempt that results in a serious medical emergency/injury to any person in the care of the organization or on the organization's property.

3) Every effort will be made to protect the rights of the persons involved in a critical incident, especially their confidentiality. No information will be released without the written consent of the person involved, unless it is an incident that requires reporting to local authorities within 15 minutes or emergency medical information that is permissible through prior consent at orientation to services.

4) In response to a physical injury or medical emergency incident, organizational policy and procedure will be followed.

5) If it appears that medical assistance is needed, the staff member will ask the individual involved for their permission to seek help. If the individual refuses, or otherwise does not consent, but requires medical attention based on the staff member's observation, the staff member should seek medical personnel to offer assistance.

6) Once the immediate situation is stabilized, promptly report all incidents that fit the reporting criteria. If you are unsure if an incident fits the reporting criteria, contact your supervisor for guidance.

7) Staff members who witnessed the incident, or to whom an incident was reported, will complete the Critical Incident Form as soon as the situation is within control. Upon completion of the form, the following procedures are to be followed:

    a. The form will be routed via paper copy to the Safety Officer.

b. The Safety Officer, will be responsible for further investigation and completing the investigative response form for the reported incident.

c. Both the completed critical incident form and the completed response will be printed by the Quality and Compliance Officer and maintained in a locked file of all critical incident reports and responses.

d. All critical incidents and responses will be reviewed on a monthly basis by the leadership team. The review will assess causes and trends, develop strategies and interventions to prevent recurrence, develop education and training for personnel to minimize future recurrence, and ensure that internal and external reporting requirements are met. This information will additionally be used to assist in the revision of the organization's risk management plan, insurance coverage, compliance planning, and code of conduct.

8) All critical incidents are considered confidential information. All printed Critical Incident Reporting forms and distributed copies are to be maintained in a safe and secure location by the staff member possessing them and are never to be reviewed by unauthorized personnel. All specific information related to the actual event will be contained within the appropriate forum of discussion and is not to be disclosed outside of formats authorized by organizational policy and procedures. Critical Incident forms are not to be filed in the record of the person served.

9) Critical incident reports have serious legal implications. They are not to be circulated beyond the outlined pathways of circulation.

10) In any situation in which a person refuses medical care for an observable medical condition resulting from a critical incident, it should be clearly documented on the critical incident form that medical care was refused.

D. Procedures for Completing the Critical Incident Form:

1) The staff member involved or a staff member witnessing the critical incident should complete the form.

2) The date, time of the event, and the location are completed.

3) Information about the Patient: The identity and chart number should be completed for each patient involved in the incident.

4) Staff Information: The identity and position of the staff members involved.

5) Visitor Information: The identity of any visitors involved in a critical incident, and the reason they are in the facility or on the property.

6) The type of incident.

7) A description of the event by providing a specific behavioral description of the event, in addition to listing all witnesses.

8) Identification of any immediate action that was taken to alleviate the situation and the rational for the actions.

9) Reporter's signature and date.

E. Reviews of initial critical incident reports may result in further investigation and clarification to assess outcomes and formulate recommendations. This may include interviews of persons served and visitors on a voluntary basis, and interviews of staff members.

1) The leadership team will summarize past critical incidents, seek to discover any trends that may be occurring, investigate causes related to trends, and make changes in policy, procedures, and/or operational guidelines, if appropriate. This information will additionally be used to assist in the revision of the organization's risk management planning, insurance coverage, compliance planning, and code of conduct.

Policy 09.03 - External Inspections of Facilities

I. POLICY:

A. It is the policy of ACR to seek outside expertise to assist in assessing the overall safety of our facilities to assure that our services are conducted in an environment that is safe for consumers, employees, and visitors.

II. PROCEDURES:

A. The CEO is responsible for the oversight that will ensure external safety inspections at all locations are completed a minimum of twice every three years and will facilitate the following processes:

1) The CEO will schedule all external safety inspections in cooperation with the Leadership Team and will serve as the contact and liaison with inspection personnel and organizations.

2) Members of the Leadership Team who are designated representatives for the organization will be responsible for facilitating the external inspections, obtaining a copy of the inspection report, and forwarding a copy of the report to the CEO at the monthly Leadership meeting.

3) The Leadership Team will work in coordination with the CEO to assure that all recommendations that are a result of the safety inspection reports are followed-up and corrections of deficiencies are completed

4) All inspection reports and correction activities will be reviewed by the Leadership Team and noted in meeting documentation. The CEO will report the results of the inspections, follow-up activities, and recommendations to the staff to ensure the organization is utilizing the information to increase the level of safety throughout its operations.

5) The CEO will maintain a record of the inspection report, including recommendations and corrections made. This record will be maintained in the safety book/binder and copies will be submitted to the Leadership Team for inclusion in the organization's overall safety record book.

B. Two inspections every three years at the designated office will be conducted by two separate entities, such as the fire department and the organization's insurance company, to provide a broad perspective of safety issues.

C. Local regulatory guidelines may require specific safety inspections on a yearly basis by the fire department. While the organization will utilize such inspections to further increase the safety of its operations, they will not serve as a substitute for an additional inspection by an entity other than the fire department.

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Policy 09.04 - Emergency and Evacuation Plans & Drills

I. POLICY:

A. It is the policy of ACR Health Services to protect staff, volunteers, persons served, family/supports, stakeholders, and property in the event of an emergency or disaster. All potential emergencies cannot be anticipated; therefore, emergency plans shall provide for adaptability to multiple situations.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight of emergency disaster plans, drills, and ensuring that organization facilities, staff, persons served, their family/supports visitors, and stakeholders are prepared to respond effectively to any emergency.

B. In addition to staff and volunteer participation in drills, persons served, their family/supports visitors, and stakeholders will be included in drill exercises.

C. ACR Health Services will maintain policies and procedures that outline specific guidelines for addressing emergency situations that may affect the health and safety of staff, volunteers, persons served, family/supports, and other stakeholders. These policies and procedures will meet the requirements of applicable authorities and are appropriate to the locale of service provision and organizational facilities.

D. Emergency drills and evacuation will be conducted, at each location at a minimum of annually, and on each shift. These include:

1) Severe Weather/Natural Disasters typical to the Atlanta Metro Area. Note: Weather/Natural Disasters Typical to the Atlanta and Central Georgia are Tornadoes and Violent Wind.

2) Fire and Evacuation.

3) Workplace Threats and Violence which may include explosions, gas leaks, terrorism, use of weapons, or aggressive acts by staff, volunteers, persons served, family/supports, stakeholders, or intruders.

4) Utility Failures.

5) Medical Emergencies.

6) Bomb Threats.

7) Other Emergency Situations as identified.

E. Emergency procedures will address:
- When evacuation is appropriate.
- Complete evacuation from the physical facility.
- When sheltering in place is appropriate.
- The safety of all persons involved including staff, volunteers, persons served, family/supports, stakeholders.
- Accounting of all persons involved.
- Temporary shelter as applicable.
- Identification of essential services.
- Continuation of essential services.
- Emergency phone numbers.
- Notification of the appropriate emergency authorities.
- Communication with local stakeholders.

F. The Safety Officer will be responsible for the following emergency preparedness activities at their respective facilities:

1) Conducting all required emergency drills at their respective site locations, on each shift, at least annually.

2) Conducting drills in a manner and with the necessary precautions to not unduly disturb persons served or the ongoing provision of services.

3) Completing the Emergency Drill Reporting Form.

4) Educating and informing staff, volunteers, and as appropriate, persons served, family/supports, stakeholders following drills regarding response patterns and improvements in responses. Information should be appropriate to the individual(s) who are being educated and informed.

5) Reporting the results of emergency drills and providing a copy of each report to the Director of Quality Assurance and Compliance.

6) Supporting and implementing action plans that are developed by Leadership Team when the need for improvement is identified.

7) Maintaining a record of all drills at each site in the safety book/binder.

G. Actual emergencies at any site will be reported as per the Critical Incident Policy and will follow procedures included in that policy in addressing safety and quality improvement activities following an actual event.

H. The Director of Quality Assurance and Compliance will be responsible for development and revision of emergency preparedness plans based on results of ongoing drills, actual events, and recommendations provided by the organization's critical incident policy and procedures process.

I. All staff members are responsible for maintaining a working knowledge of emergency procedures through education, training, competencies, and simulated emergencies/drills. A comprehensive orientation at the time of employment will include an overview of emergency and safety procedures. Specific responsibilities of staff members regarding emergency/safety procedures will be defined in job descriptions and through job site orientation and training.

J. ACR Health Services policies and procedures outline basic approaches for responding to various types of emergencies; however, each facility may have additional components due to the nature of the physical layout of the facility, types of programs and services, special populations, and local regulatory requirements. It is the responsibility of the Safety Officer to ensure that the special needs and characteristics of each facility are addressed in addendum policy and procedure, and that these special needs and characteristics are communicated to all affected persons and the health and safety committee.

K. Leadership will designate Program Directors/Leaders to communicate with additional stakeholders beyond participating staff who will be notified regarding emergency incidents and drill results. This may include staff at other locations, volunteers, persons served, family/supports, community partners, public health department, local law enforcement, the board of directors, investors, and others as identified based on the health or safety drill/event.

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Policy 09.05 - Severe Weather and Natural Disasters

I. POLICY:

It is the policy of ACR to protect persons served, employees, visitors, and property in the event of a severe weather emergency or natural disaster. All potential emergencies cannot be anticipated, therefore, emergency plans shall provide for adaptability to multiple situations.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight of emergency disaster plans and drills and ensuring that the organization's facilities are well prepared to respond effectively to any emergency.

B. Specific procedures will be maintained for severe weather and natural disasters. In addition, emergency severe weather and natural disaster drills will be conducted at each site on an annual basis.

C. The overall components of the organization's severe weather emergency plans are as follows:

1.) Severe weather is defined as any weather condition or natural event that has the potential to cause physical harm and/or property destruction. These events include ice, snow, severe thunderstorms, tornados, and flash floods. Procedures for severe weather are as follows:

a. If a severe weather, tornado watch is issued or ice/snow is predicted, each site shall access radio or television reporting that provides information from the National Weather Service.

b. In the event of a "watch" the following steps will be taken:

1. In the event of a "watch," employees on duty will be informed of procedures to be taken in the event a "warning" is declared.

2. During “watch” periods, all persons served and employees will be encouraged to limit trips and transportation to and from the site.

3. In the event of a severe weather or tornado warning, all persons within the facility will immediately move to the designated areas in the interior of the building that are designated on the posted evacuation routes.

4. Employees will assist persons served in arriving at the designated safety locations, and if time permits, will close all windows and blinds and all doors.

5. The Safety Officer, or designee, will secure the first aid kit, flashlights, and a radio, and maintain them in the area being used for shelter.

6. The Safety Officer shall oversee the process of moving to the designated safety location(s) and conduct a head count when this activity is completed.

7. The Safety Officer shall announce the end of the need to remain in the designated location when the warning is no longer in effect, according to the national weather service.

c. In the event of other severe weather events like ice/snow, the Executive Director or Safety Officer will monitor local news stations for recommendations from the Governor’s Office and will make a judgment based on the closing of government offices and schools. If the severe weather event occurs during normal operating hours, ACR operations may be curtailed and program participants and staff released early.
d. In the case of snow/ice predications impacting ACR’s service area, the Executive Director or designee will monitor local new reports and make a judgment of whether to delay reporting times or suspend operations based current weather forecasts. The Executive Director or designee will send a notification via text message to the Leadership Team and administrative preferably no later than 7:00 a.m. if office operations will be suspended or delayed because of the ice/snow emergency.

e. The Safety Officer will be responsible for contacting any emergency entity that may be needed due to injuries or events such as power loss and/or broken utility lines.

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Policy 09.06 - Power Failures

I. POLICY:

It is the policy of ACR to protect persons served, staff members, visitors, and property in the event of a power failure. All potential emergencies cannot be anticipated; therefore, emergency plans shall provide for adaptability to multiple situations.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight of emergency disaster plans and drills and ensuring that all of the organization's facilities are well prepared to respond effectively to any emergency.

B. Specific procedures will be maintained for power failures. In addition, power failure drills will be conducted at all service sites on an annual basis.

C. The following are the overall components of the organization's power failure plans. These serve as basic approaches to responding to power failures; however, individual service sites may have additional components due to the nature of the physical layout of the facility, types of programs and services, special populations, and local regulatory requirements. It is the responsibility of the Safety Officer to ensure that the special needs and characteristics of each facility are addressed in additional policy and procedure, and that these special needs and characteristics are communicated to all affected persons and the health and safety committee. The overall components of the organization's power failure emergency plan is as follows:

1) A power failure is defined as a full or partial power outage that affects the ability of the organization to provide a normal range of services and operations and may compromise the safety of occupants of the facility.

2) In the event of a power failure, remain calm. If in an interior office without natural light or emergency lighting, utilize the personal flashlight provided for safe egress to evacuate to a hallway area. Assist persons served to the lighted area, if necessary. If emergency lighting is not available, in hallway areas, continue to utilize your personal flashlight.

3) If using a computer, turn it off to prevent damage due to power surges, prior to leaving your work area.

4) The Safety Officer will check circuit breakers and the main breaker panel and, if the power outage is not attributed to the internal system, will turn off all breaker switches and call the local utility company to report the outage.

5) If it is deemed necessary by the Safety Officer or the facility director, evacuate the building by following evacuation procedures.

6) If evacuation occurs, lock the entrances to the facility to prevent re-entry.

7) The CEO or designee will determine whether the site will be shut down and, in consultation with utility company employees and/or other staff, will determine when the building is ready for occupancy.

8) Prior to re-entry, the organization's Safety Officer in consultation with the utility company, will ensure that the facility is in ready for occupancy by completing the following tasks:
    a. Re-booting computers
    b. Switching breaker switches back on
    c. Checking all lights to ensure that lights are working
    d. Switching off any emergency power supply that may be in use
    e. Checking telephones, fax machines, printers and or other vital equipment to ensure it is working and not damaged

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Policy 09.07 - Evacuation and Fire

I. POLICY:

It is the policy of ACR to protect persons served, staff members, visitors, and property in the event of a fire emergency or in the event that the physical plant in which services are being provided needs to be evacuated. Evacuations can occur for a variety of reasons, including fire emergencies, violence or aggressive behavior, a utility emergency, such as a natural gas leak, or a natural disaster, such as an earthquake, that may leave the structure unsafe to inhabit.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight of emergency disaster plans and drills and ensuring that the facility is well prepared to respond effectively to any emergency.

B. Specific procedures will be maintained for fire emergency and evacuation of the facilities. Emergency fire and evacuation drills will be conducted at each facility on an annual basis. The Safety Officer will be responsible for coordination of the drills and completing the Safety Drill Form following the drill. A copy of the form will be maintained in a safety binder at the site location, and distributed during reporting to the Leadership Team.

C. Fire Procedures: The following are the overall components of the organization's fire emergency plans. These serve as basic approaches to responding to fire emergencies; however, each site may have additional components due to the nature of the physical layout of the facility and local regulatory requirements. It is the responsibility of the facility Safety Officer to ensure that the special needs and characteristics of each facility are addressed in additional policy and procedure, if appropriate, and that these special needs and characteristics are communicated to all affected persons and the leadership team. The components of the organization's fire emergency plans are as follows:

1) In the event of the discovery of a fire, evacuate all individuals from the immediate area.

2) Close all doors to contain the fire.

3) If the fire is small, attempt to contain it by using a fire extinguisher.

4) Announce that there is a fire in the building and the need to immediately evacuate.

5) Call 911 and report the fire, providing the name and address of the site.

6) Assist in the evacuation process and account for all persons served, employees, and visitors.

7) To expedite the evacuation process, all ambulatory persons served and visitors are evacuated first, followed by staff members who will assist all others in evacuation.

8) All persons will be evacuated and assembled at a location that is pre-determined by each facility as the evacuation assembly area.

9) The safety officer or designee will provide any special information to arriving emergency personnel such as size and location of fire and location of any flammable or explosive items, and will relinquish control of the situation to the local authorities.

10) The fire department will be the final authority in determining building re-entry.

11) If the facility cannot be re-occupied, the designated employee in charge of managing the site will manage, through consultation with the CEO, the continuation of essential services, as per those procedures contained in this policy.

12) The Safety Officer will be notified as soon as possible of the incident and an incident report will be completed and processed as per the Critical Incident Policy.

D. Evacuation Procedures: In the event of an emergency that requires a facility to be evacuated, the following procedures will be as follows:

1) Evacuation of the facility shall occur should any of the following events occur:

a. Fires: If it is immediately determined that the extent of the fire cannot be contained with quick and direct actions, the building will be evacuated.

b. Violence and/or Aggression: If a crisis situation occurs that involves a direct threat to any persons in the building, the building will be evacuated.

c. Utility Disruption or Crisis: Situations that will necessitate evacuation in this area include gas leaks and electrical malfunctions determined to present a health risk.

d. Noxious Odors or Fumes: If it is determined that there are odors or fumes that are a health risk due to eye, skin, or lung irritation, the building will be evacuated.

e. Bomb Threat: In the event of a bomb threat made toward the organization, the building will be evacuated.

2) In the event it is determined the building should be evacuated, the following procedures will be followed:

a. The Safety Officer will inform all staff of the evacuation order through verbal communication.

b. All staff in direct care service areas or in direct contact with persons served will assist the patient(s) in exiting the building through the exits according to the facility emergency exit plan/map. Staff not in direct contact with persons served or patient areas will immediately exit the building according to the facility emergency exit plan/map. Staff in patient areas will check the rest rooms to ensure that all persons evacuate.

c. The Safety Officer will exit the building with the safety binder, in order to access information on contacting emergency personnel.

d. All staff and persons served will proceed to the designated evacuation area (the rear exit of the facility) as quickly as possible.

e. The Safety Officer, or designee, will determine if all staff and persons served are present and out of the building, through surveying staff to determine if all persons served being treated during the time of evacuation are accounted for and determining if all staff are also accounted for.

f. Should it be determined that someone in the building is not present outside the building, the Safety Officer will determine if the nature of the emergency presents a threat to life and/or health to the degree that it would not be prudent to re-enter the building briefly to seek the location of the missing individual or individuals. If it is determined that the situation would allow a quick re-entry to locate the missing individual, the Safety Officer will briefly re-enter and call out the name of the individual. If there is not a response, the Safety Officer will exit the building and wait for emergency personnel to arrive and take control of the situation.

g. Should the building not be of the condition to be re-occupied to provide services, all records have been maintained electronically and be retained electronically until the current facility or another facility can be brought back into full service operation.

h. Emergency phone numbers are for use in the event of an evacuation and will be maintained on the back-side of the Safety Binder.

i. Once an emergency evacuation has occurred, the building cannot be reoccupied until the responding emergency authority grants permission that the health and safety of staff and persons served is no longer compromised. Should an immediate re-occupation not be allowed by the authorities, occupation will be determined through the authority of the entity that is charged to bring the building back into compliance with health and safety standards (i.e. gas company, fire department, building inspector, etc.).

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Policy 09.08 - Bomb Threats

I. POLICY:

A. It is the policy of ACR to provide prompt attention and appropriate assistance to persons served, staff members, and visitors in the event of a bomb threat, and the need for evacuation. All potential emergencies cannot be anticipated; therefore, emergency plans shall provide for adaptability to multiple situations.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight of emergency disaster plans and drills and ensuring that all of the organization's facilities are well prepared to respond effectively to any emergency.

B. Specific procedures will be maintained for bomb threats.

C. The following are the overall components of the organization's bomb threat and emergency plans. These serve as basic approaches to responding to bomb threats. The overall components of the organization's a bomb threat emergency plans are as follows:

1.) In the event of a bomb threat received by telephone (a call in which an individual indicates a bomb has been placed within or near the facility):

a. Obtain as much information as possible from the caller, noting details of voice, speech patterns, and any background noise.

b. Ask where the bomb is and when it will go off, and document any information that is provided by the caller.

2.) If the threat is received by letter or note:

a. Do not handle the letter or note any more than is necessary so evidence is not compromised.

3.) If you notice a package, container, briefcase, or other object that is unattended and is out of place within the facility, does not have common identifiable markings or labeling, and is not recognized as belonging to an employee, person served, or visitor, proceed as follows:

a. Upon the discovery of a suspicious object/package/container, do not touch or move it.

b. Ask people in the area the object was discovered if they know what it is or if it belongs to someone.

c. If no one claims the object or cannot identify what the object is, notify the facility safety officer, or facility manager/director, who will determine if the facility should be evacuated and law enforcement authorities summoned, based on further investigation within the facility regarding the ownership of the suspicious package, container, briefcase or other type of unattended object.

d. If the object/package cannot not be identified, or is not claimed and identified by someone within the facility, evacuate the building and summon/contact law enforcement authorities.

e. Wait for the arrival of law enforcement authorities outside the building and turn over management of the unidentified object to law enforcement upon their arrival.

f. Re-enter the building and resume services only after clearance is obtained from the public officials managing the situation.

4.) In all situations involving the threat of a bomb, follow these procedures:

a. Remain calm and do not alarm persons served, visitors, or other staff members.

b. Immediately seek the CEO or Safety Officer to discuss the situation.

c. The CEO and/or the safety officer, is responsible for contacting the police and activating the evacuation procedures.

d. Evacuation will be handled as per the organizational/facility evacuation policy and procedures.

e. In situations where the building/facility has been evacuated, agents of the police or other authorities will assess the situation and, if the present danger is terminated, will then inform the CEO or designee. Only the police authority may activate the “all clear” and only then may anyone enter the building.

f. Following the all clear, crisis debriefing procedures will be followed, as appropriate.

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Policy 09.09 - Medical Emergencies

I. POLICY:

A. It is the policy of ACR to provide prompt attention and appropriate assistance to persons served, staff members, and visitors in the event of a medical emergency. All potential emergencies cannot be anticipated; therefore, emergency plans shall provide for adaptability to multiple situations.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight of emergency disaster plans and drills and ensuring that all of the organization's facilities are well prepared to respond effectively to any emergency.

B. Specific procedures will be maintained for medical emergencies. In addition, medical emergency drills will be conducted at each site on an annual basis.

C. The overall components of the organization's medical emergency plan are as follows:

1.) A medical emergency is defined as an incident that requires interventions beyond simple first aid available at the facility in order to stabilize a condition that may result in a serious medical outcome. Conditions include, but are not limited to, excessive bleeding which is unable to be controlled, accidents involving serious injury, failure or obstruction of the respiratory system, failure of the circulatory system, chest pain or severe abdominal pain, loss of consciousness unrelated to predictable seizure activity, or any type of distress that is determined to seriously limit an individual's normal level of daily functioning.

2.) When an event occurs that is determined to be an emergency health care incident, 911 will be immediately called to access emergency personnel to assist and transport the individual to medical services.

3.) The organization's critical incident policy will be followed for all medical emergency events.

4.) If determined to support the stabilization of a serious and acute medical condition, staff members who hold current certification in CPR and First Aid will implement CPR and/or First Aid procedures, when appropriate, to stabilize a condition prior to the arrival of external emergency personnel.

5.) If the individual is a person served, the Emergency Medical Treatment Form will be accessed, contact made with the emergency contact names, and pertinent information will be given to the transporting emergency technicians. All Emergency Medical Treatment Forms will include:

a. Name, address, and telephone number of the physician to be called.

b. Name, address, and telephone number of a relative or other person to be notified.

c. Medical insurance company name and policy number, or Medicaid/Medicare number.

d. Information concerning the use of medication, medication allergies, and significant medical problems.

D. Employees will not transport individuals in their personal vehicles and/or the organization's vehicles in emergency health care situations.

E. Following containment of the emergency, a progress note will be completed in the record of the person served and a Critical Incident Report form will be completed.

F. If the emergency involves an employee, the designated staff responsible for the human resource files will access the Employee Emergency Contact information.

G. Contact will be made with the emergency contact person named, if requested to do so by the staff member. A contact will always be made if the staff member is incapacitated and unable to request or deny the contact.

H. The telephone number of the local poison control center will be posted throughout the organization. All staff members and persons served will be orientated to the location of this information.

I. In the event of poisoning or drug ingestion that has caused an acute medical emergency, staff members will call **(poison control 1-800-282-5846)** and provide the following information: age and weight of the person, names of the substance(s) ingested, strength, and amount ingested if known, and the general condition of the person. Vomiting or the use of Ipecac syrup will not be used unless specifically directed by personnel of the poison control center.

J. Medical clearance must be obtained in writing from the treating physician prior to persons served returning to services, or staff members returning to employment duties, if a medical emergency required a response from emergency responders.

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Policy 09.10 - Workplace Violence

I. POLICY:

A. It is the policy of ACR to protect persons served, staff members, visitors, and property in the event of threats and violence in and around the organizations facilities. All potential emergencies cannot be anticipated; therefore, emergency plans shall provide for adaptability to multiple situations.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight of emergency disaster plans and drills and ensuring that all of the organization's facilities are well prepared to respond effectively to any emergency.

B. Specific procedures will be maintained for workplace threats and violence. Workplace threats and violence drills, to gauge the organizations potential response to an actual event, will be conducted at each site on an annual basis.

C. The overall components of the organization's workplace threats and violence plans are as follows:

1.) Workplace threats and violence is defined as any situation in which there is a perceived threat of violence, or a situation where violence is or has occurred. Procedures to provide the optimal response for safety apply to persons served, staff members, and visitors who may exhibit threats of violence or actual violent acts.

2.) Staff members should exercise common sense in any situation with an aggressive person. If a situation involves a weapon, such as a knife or gun, do not attempt to remove the weapon from the individual.

3.) If you or anyone else is assaulted or physically threatened by another individual while conducting business, if possible remove yourself from the situation, call for help (vocally or by phone), and/or notify another staff member to summon the police by calling 911.

4.) Do not attempt to engage in any type of physical restraint with a person who is threatening violence, unless your life is in imminent danger.

5.) If you cannot remove yourself from the situation, follow the guidelines provided through the organizational workplace violence training regarding de-escalation techniques for dealing with such situations.

6.) If you are not directly involved in the situation, seek to assist in the evacuation of persons served, visitors, and staff from the building, according to the evacuation policy and procedures.

7.) At no time should any staff members put themselves at harm in an attempt to diffuse a situation. Always attempt to remove yourself and seek local law enforcement assistance.

D. The following procedure is to be used to notify staff members of threatening behavior without alarming the aggressor if the situation, such as being alone with the aggressor in a closed office or isolated from other staff who can aid you with the situation, warrants such an approach:

1.) If you believe the situation is such that it warrants support and assistance from other staff, Indicate to the person in your office or work area that you take their actions, behavior, and/or anger very seriously and that you do not want to be disturbed so you can focus on them. Let them know that you are going to call the front desk or receptionist to have them hold your phone calls. Then call a co-worker, or a person designated by the organization as the point person for violent situations, from your phone and request that they **"hold all your calls**." This will serve as the "code" or the notification that their presence is needed in your office to assist you with a potentially violent situation.

2.) If you believe that the situation is such that it warrants law enforcement intervention, indicate to the person in your office or work area that you take their actions, behavior, and/or anger very seriously and that you do not want to be disturbed so you can focus on them. Let them know that you are going to call the front desk or receptionist, or designated person and have them **"cancel your next appointment".** This will serve as notification that an emergent situation is occurring and they are to contact local authorities for assistance immediately and assist you with the situation.

3.) Example:

a. "This is Joe, I am dealing with something very important. Could you hold all my calls"? This is a call for staff assistance.

b. “This is Joe, I’m in my office. I’m dealing with something very important. Could you cancel my next appointment?” This is a call for you to summon the police, as well as immediate staff assistance.

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Policy 09.11 - Emergency Equipment and First Aid

I. POLICY:

A. It is the policy of ACR to ensure that appropriate equipment is available to assist and support the health and safety of persons served, employees, and visitors should an emergency occur at a facility.

II. PROCEDURES:

A. The Safety Officer is responsible to ensure that all appropriate equipment to support the health and safety of occupants is available and properly maintained at their assigned facility, through the use of the self-inspection checklist and procedures contained in the Self-Inspection Policy.

B. Each facility will have the following safety equipment and supportive aids available:

1) ABC type fire extinguishers mounted and/or placed at easily identifiable and accessible locations throughout the building.

2) Signs clearly indicating the placement of fire extinguishers.

3) Smoke detectors that are battery powered and have both audible and visual alarm indicators.

4) Clearly posted exit signs.

5) Clearly posted emergency exit plans for evacuation and fire safety that also include location of fire extinguishers and first aid kit.

6) A first aid kit.

7) Signs indicating the location of the first aid kit.

8) The biohazard equipment appropriate to the services provided.

9) Readily available emergency data for patients and employees that can be accessed promptly in the event of a medical emergency.

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Policy 09.12 - Organizational Safety Responsibility

I. POLICY:

A. ACR values the health and safety of the persons we serve, employees, and visitors, and maintains a comprehensive safety program to promote a safe environment within our program sites.

B. It is the policy of ACR to maintain an environment that conforms to all legal, regulatory, and accreditation health and safety requirements, and to designate persons responsible for the planning, implementation, and oversight of a comprehensive organization-wide health and safety program. ACR health and safety procedures will focus on two major areas: the identification, monitoring, evaluation, reduction, or elimination of health and safety risks; and planning and preparation to maximize the health and well being of individuals in the event of disasters or emergency situations.

II. PROCEDURES:

A. Responsibility for health and safety programming, procedures, and practices are designated as follows:

1) The CEO/Executive Director is charged with the overall responsibility of health and safety management for the organization. Within this role, all health and safety policy and procedure receives final approval; risk management and critical incident issues that affect the overall stability and continuing operation of the organization are reviewed; serves as the organizational health and safety point-of-contact regarding regulatory or third party inquires; and provides broad support for training initiatives and fiscal stability to support ongoing health and safety programming and practices.

2) The ACR Safety Officers are responsible for the overall coordination of the health and safety program at each program site site. In carrying out this role, the Safety Officers will provide as-needed and monthly reports to the management team regarding the health and safety conditions and activities at each program site, conduct program site emergency drills and inspections, document and report the results of drills and inspections, seek to make corrections and improvements based on the drill and inspection outcomes, and ensure the health and safety policies

and procedures are being carried out within each program site's daily operations. In addition, the Safety Officers will be responsible for the maintenance of the program site's Safety Binder, in accordance with the requirements for the binder. The Safety Officers will report directly to the CEO with regard to health and safety requirements, and will communicate all information related to health and safety practices, concerns, and/or issues in a manner that ensures that the health and safety of all persons served, employees, and stakeholders is upheld to the highest degree possible.

3) A Safety Binder will be maintained at each program site by the Safety Officer for the purpose of enhancing the structure and organization of each site's safety program. The binder will serve to centrally locate all health and safety documentation that is associated with required safety activities.

   Each safety binder will be organized as follows:

   a. Binder Index

   b. Yearly Safety Activity Requirements Grid

   c. Section One: Outside/External Inspection:

      (1) A document that includes all the areas that were inspected by an outside authority, and any recommendations that were made to improve safety

      (2) A document, or evidence "in writing" that details how and when any recommendations were addressed by the organization that were made by the outside inspection.

   d. Section Two: Self-Inspections

      (1) Completed self-inspection checklists. The documents should note all areas inspected, any areas not meeting items on the list, and documentation or evidence "in writing" that documents how and when any areas needing improvement were addressed.

      (2) Copies of the self-inspection form.

e. Section Three: Safety Drill Procedures

(1) All safety drill policies and procedures

f. Section Four: Safety Drill Reports, Recommendations, Actions

(1) Completed Safety Drill Reports for each of the seven required drill areas for each year, which include a review of the drill and recommendations for improvements.

(2) Any documentation of improvements made

(3) Copies of the safety drill forms

g. Section Five: Incident Reports

(1) Paper copies of incident reports that have been completed at the program site.

h. Section Six: Safety Documentation

(1) Sections of any meeting minutes that note health and safety issues, actions, and/or recommendations are highlighted and placed in this section.

i. Section Seven: A copy of all Health and Safety Policies and Procedures

4) Ongoing oversight of the organization's health and safety policies and procedures is the responsibility of the CEO. Within this role, the Leadership Team will ensure that all regulatory requirements are carried out within the day-to-day operations of the organization through monitoring, supporting, and guiding the following activities:

a. Health and safety policy and procedure development, implementation and monitoring.

b. Education and training during orientation for persons served in health and safety practices.

c. Initial and ongoing education and training of employees in health and safety issues.

d. Incident reporting and use of information.

e. Immunization and infection control.

f. Facility safety monitoring, correction, and improvement.

g. Fire and occupancy certification.

h. Disability access.

i. Food preparation and storage areas.

j. Emergency preparedness drills and documentation.

k. Emergency response and documentation.

5) All employees are expected to perform their jobs in a safe manner. Employees are primarily responsible for their own health and safety and the safety of persons in their care. This responsibility includes proper hand washing, storage and use of chemicals, control of bodily fluids/blood borne pathogens, and knowledge of fire evacuation procedures, use of protective gear, managing behavior to prevent violence, and reacting to the potential for violence with measured, appropriate interventions. All employees are responsible for immediately correcting conditions or practices that are unsafe or unhealthy. Unsafe or unhealthy practices and/or conditions are to be reported immediately to the appropriate staff, as per policy and procedure. Employees are required to promptly report any accident, injury, or incident (real or suspected), and any conditions or practices, which cannot be corrected by a staff member, should be reported in accordance with the appropriate procedure (safety drill and/or inspection reports, incident reports, corporate compliance reports, direct communication with supervisor).

B. All areas of health and safety are detailed within written policies, procedures, handbooks and plans. These areas include the following:

1) External Safety Inspections.

2) Internal Safety Self-Inspections.

3) Emergency/Disaster Plans and Drills.

4) Safety Information Dissemination.

5) Emergency and First Aid Equipment.

6) Critical Incident Reporting.

7) Use of Tobacco Products.

8) Client Medications.

9) Infection Control/Universal Precautions/Biohazards.

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Policy 09.13 - CPR and First Aid Training

I. POLICY:

It is the policy of ACR that at least one individual is available during all hours of operation that is trained in basic first aid and cardiopulmonary resuscitation (CPR), and that the presence of trained personnel is available at all program sites, when accompanying persons served on community outings, and when providing home-based services.

II. PROCEDURES:

A. The Safety Officer will be responsible for ensuring that the CPR and First Aid Training Policy is fully integrated in the safety practices of the organization.

B. The Quality and Compliance Officer are responsible for ensuring that CPR and first aid trained personnel are available on each shift throughout the daily provision of services.

C. All staff members who work in positions with direct consumer contact are required to receive CPR and First Aid training.

D. Human Resources will be responsible for maintaining and monitoring the training records and training updates for all staff members who are required to be CPR and First Aid certified. All position descriptions of staff members who are required to receive training and maintain certification will reflect this requirement.

E. All new staff members will be notified at orientation if CRP and First Aid training is required of their position, and will be provided the necessary administrative leave to accommodate the training.

F. CPR and First Aid training will be provided free of charge through local organizations that provide such training e.g., American Red Cross.

G. All staff members are responsible for receiving the necessary continuing education/training and providing Human Resources with a current record of training.

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Policy 09.14 - Individuals Served in Possession of Drugs

PURPOSE: To ensure Assertive Community Recovery maintains a drug-free workplace, and confirm that recovery from chemical abuse and dependency requires complete abstinence from alcohol and/or drugs.

POLICY There may be times when a individual served acknowledges their use of substances, and either turns these over to a staff member or makes a staff member aware that they are in possession of substances. It is the policy of Assertive Community Recovery to encourage individual served honesty and also protect their confidentiality. This presents a delicate issue of disposal of these substances if staff becomes aware that an individual served is in possession of illicit or licit drugs. The following procedures, developed in collaboration with the Dekalb County Police Department and the Dekalb County Sheriff's Department, are to be followed in this type of situation.

Any individual served that is under prescribed medication must keep their medications on their person and out of sight of all individuals Served. (handbag, brief case, pocket, etc.)

DEFINITIONS:

Licit Drug(s): Licit drugs are substances that are either: a) legally prescribed to the individual served, or b) legally available (including alcohol). Many licit drugs may be used for their mood-altering effect, and are substances to which Individuals Served may become physically or psychologically addicted. Regardless of their source, if a licit drug is being abused, they may need to be disposed. Because these substances are not controlled, the legal authorities do not need to be contacted prior to disposing of these substances.

Illicit Drug(s): Illicit drugs are substances that either: a) legally prescribed but the individual served does not have a valid prescription for these medications, b) not legally available in Georgia, or c) are legally available but are restricted to age groups

other than the individual served (e.g. minor in possession of alcohol).

Possession: Includes the presence of drugs or alcohol in the possession or control of the individual served or in the individual served belongings (e.g., coat hanging in the lobby), automobile on ACR's property or while in ACR's vehicles.

PROCESS:

- If a staff member is aware that an individual served is in possession of drugs or alcohol on ACR premises, property or vehicles, they will be encouraged to disclose this information, including the whereabouts of the drugs or alcohol.
- The staff member then shall determine if the drug is a licit or illicit substance.
- If the drug is one that is prescribed to the individual served, is being taken according to the prescription, and not being used primarily for any mood-altering effect, than no further action is necessary.
- If the substance is any other type of licit drug, the individual served shall be encouraged to dispose of it in the presence of a staff member, or two staff members if possible.
- If the drug is an illicit drug, the staff member will immediately ask to take possession of the substance.
- If the individual served refuses, they shall be asked to leave the premises, including ACR property and vehicles.
- If the individual served does turn over the substance to the staff member, it shall immediately be placed in the agency safe or a locked area.
- The substance shall be turned over the Dekalb County Police or the Dekalb County Sheriff's Department as soon as possible.
- The staff member should call the police immediately following the appointment, and wait (if after hours) until they arrive to take possession of the substance.

It is important to note that confidentiality of individual served information needs to be maintained, and disclosure of the individual served name to the legal authorities should not be made. The disclosure of possession of licit or illicit drugs should be used therapeutically, and the individual served should not be punished for their honesty.

REPORTING: Notations of possession of either licit or illicit drugs shall be made in the clinical record. In addition, an incident report should be completed and submitted as soon as possible.

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Policy 09.15 - Tobacco Products

I. POLICY:

It is the policy of Assertive Community Recovery to comply with all applicable laws and guidelines regarding tobacco use, and to ensure the safety and comfort of persons served, staff members, and visitors with regard to the use of tobacco products.

II. PROCEDURES:

A. The Safety Officer is responsible for oversight that will ensure that tobacco products procedures are followed at all locations and that any further development, revision, or changes in the tobacco products policy are facilitated through the health and safety committee process.

B. In keeping with Assertive Community Recovery's desire to maintain a safe and healthy workplace, the use of tobacco products is not permitted by persons served, staff members, or visitors at any facility, except in designated areas.

C. Designated tobacco use/smoking areas will be established at each facility and will be located outside the facility. All established areas will be a minimum of 20 feet from any entrance to the facility.

D. The use of tobacco products in contractor/employee vehicles is prohibited.

E. Tobacco use in the presence of persons served in a community-based setting is prohibited.

F. The tobacco use policy will be clearly communicated to persons served and staff members through the consumer and employee orientation processes. Tobacco use by staff members in unapproved areas will result in actions as per the organization's disciplinary procedures. Tobacco use by persons served in unapproved areas will result in verbal counseling, and continued use will result in a violation of the program rules.

G. The sale of smoking products in the organization's facilities is prohibited.

H. The organization will provide, upon request, information regarding the effects of tobacco use and the availability of smoking cessation programs.

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Policy 09.16 - Weapon-Free Workplace

POLICY: It is the policy of ACR Health Services to ensure the safety of persons served, staff members, volunteers, family/supports, and stakeholders. To this end, the organization enacts the prohibition of dangerous weapons on company property by anyone, other than law enforcement acting in an official capacity.

State Weapons Laws: Employees (except convicted felons) may store a weapon in their personal, locked, motor vehicle in the company parking lot, per Georgia Code 16-11-126(a). A *motor vehicle* means any automobile, truck, minivan, sports utility vehicle or motorcycle equipped with a locked accessory container within or affixed to the motorcycle. Weapons are not allowed to be kept or stored in any company-owned or leased vehicle.

DEFINITIONS:

"Company property" is defined as all company-owned or leased buildings and surrounding areas such as sidewalks, walkways, driveways, and parking lots under the company's ownership or control. This applies to all company-owned or leased vehicles.

"Dangerous weapons" include firearms, explosives, biochemical threats, knives, aggressive/assaultive physical behavior (causing bodily harm), and any other weapons that might be considered dangerous or that could cause harm.

PROCEDURES: All persons are subject to this standard: staff, volunteers, persons served, family/supports, and other stakeholders***. A conceal and carry permit does not supersede company policy.***

1. The Safety Officer or designated staff member is responsible for oversight to ensure that the weapons policy is strictly followed. All incidents involving dangerous weapons will be addressed appropriately and reported through the critical incident process. Local law enforcement will be notified regarding failure to comply with this policy.
2. Should a staff member detect other staff, a volunteer, person served, family/support, or other stakeholder is in possession of a weapon on the organization's property, they will advise the person of the policy prohibiting possession of such item(s) and instruct them of the need to remove the weapon from the property.

   a. Failure of anyone to comply with the request for removal of a weapon from company property will result in the removal of the individual from the property via contacting external authorities for support.
   b. If the situation is volatile, staff will immediately alert the Safety Officer or other appropriate staff, and external authorities will be contacted.

3. ACR Health Services reserves the right at any time and at its discretion to **search** company owned or leased property including vehicles, packages, containers, lockers, desks, and other equipment for the purposes of determining if a dangerous weapon has been brought onto its property in violation of this policy.
4. Staff not complying with this policy may receive disciplinary action consistent with the workforce disciplinary action for violation of policies and procedures, up to and including termination.
5. Volunteers, persons served, family/support, and other stakeholders who do not comply with this policy may be terminated from the program and/or banned from the property.
6. To alert and remind staff, volunteers, persons served, family members and stakeholders, signage will be posted in visible areas upon entry to the facility, indicating that no weapons are allowed in the building except in the possession of law enforcement.
7. Staff and volunteer will receive documented training regarding de-escalation, workplace violence, dangerous weapons, and reporting of critical incidents upon hire and annually.
8. Persons served and family/supports will receive information regarding health and safety policies addressing workplace violence, aggression, and weapons in the client handbook and/or during orientation to the program.

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Policy 09.17 - Infection Control and Universal Precautions

PURPOSE:

To ensure that the consumer and staff have a safe and clean environment. The focus of infection control is the reduction of the spread of infectious disease.

POLICY:

ACR will ensure that all steps are taken to reduce the risk and spread of infectious disease.

PROCESS:

- Staff will receive training in Infection Control according to OSHA guidelines. Consumers at risk will also receive education, which will be incorporated in their treatment plan.

- The following are a list of popular Infectious diseases that will be addressed in the Infection Control Training:
    1. Hepatitis
    2. Influenza
    3. Tuberculosis
    4. Sexually transmitted disease
    5. AIDS/HIV

- ACR will practice universal precautions to prevent the spread of infection.

- Disposable items such as dressings, diapers, tissue, etc. shall be placed in a plastic bag placed in a container with a lid immediately.

- All contaminated items will be disposed of to prevent possible contamination of others.

- Bodily fluids and waste from an infected person shall be flushed down the toilet, which should be disinfected immediately.

- An area contaminated with spilled urine, blood, pus or vomit should be cleaned and disinfected with bleach solution.

- All reusable equipment shall be thoroughly cleaned, disinfected and sterilized before reuse.

When Consumer or Staff exposure is reported the following steps will be taken:

- ACR will complete an Incident Report Form.
- A copy of the form will be placed in their record.
- The infected person will be instructed to contact his/her physician.
- The County Department of Health will be notified, as appropriate. The notification will be coordinated through the person's physician.
- The infected person will be required to give a copy of treatment result to the Chief Executive Officer or designee to be maintained in their record.

Information will be gathered and given to the appropriate personnel concerning the infectious nature of each individual. Information will include:

- Type of disease
- If the person should be confined or quarantined
- Proper handling if mask, gown or gloves are required
- What materials might be infectious, such as fecal matter, pus, and or bodily fluids!
- Duration of time for confinement

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Policy 09.18 - Self-Inspections

I. POLICY:

A. It is the policy of ACR that regular comprehensive self-inspections of the overall safety of our facilities are conducted on a monthly basis, and that recommendations resulting from self-inspections are corrected to ensure the safety of the person served, employees, and visitors.

II. PROCEDURES:

A. The facility Safety Officer is responsible for oversight that will ensure safety self-inspections are completed a minimum of once every quarter, and will facilitate the following processes:

1) The designated site Safety Officer is responsible for completing self-inspections at their designated facility.

2) The Safety Officer is responsible for completing quarterly self-inspection reports and submitting/presenting the reports and results at the management team meeting.

3) All self-inspection reports and correction activities will be reviewed by the management team and noted in meeting documentation. The safety officers will report the results of the self-inspections, follow-up activities, and their recommendations for improvements to the management team to ensure the organization utilizes the information to increase the level of safety throughout its operations.

4) The safety officers will maintain a record of the self-inspection reports, including recommendations and corrections made. This record will be maintained in the safety book/binder at each location and copies will be submitted to the management team for inclusion in the organization's overall documentation of safety practices and outcomes.

B. The Self Inspection Checklist/Report Form will contain a review of the following areas related to environmental safety: Entrances/Exits, Evacuation Maps, Fire Extinguishers, Fire and Smoke Alarms, First Aid Kits, Bloodborne Pathogens, Phones, Emergency Lighting, Evacuation Diagrams, Plumbing, Chemicals and Potentially Hazardous Materials, Restrooms, Equipment, Appliances &

Machinery, Extension Cords, Storage Areas and Closets, Windows and Mirrors, Trash Receptacles, Walls and Ceilings, Floors, Furnishings, Air Quality, Pictures and Signs, Exterior, Building, and Parking.

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Policy 09.19 - Safety Officer Responsibilities/Job Duties

ACR Health Services will appoint a Safety Officer who responsibilities/job duties include:

- The Safety Officer will be responsible for maintaining the facility or organizational Safety Binder that contains all safety policies, a grid of scheduled and required safety activities, all forms for conducting and documenting safety activities, and completed documentation of all safety activities that includes recommended areas of improvement and the date and details regarding the improvements completed.

- The Safety Officer will be responsible for obtaining and facilitating an annual external inspection, obtaining a copy of the inspection report along with the criteria used for the inspection (if not included on the inspection report), clarifying with the inspector all recommendations for improvement made on the report, placing a copy in the clinic safety binder, making a copy of the report for presentation and reporting the results to the appropriate team, committee, and/or manager.

- The Safety Officer is responsible for completing a quarterly self-inspection and required documentation and submitting/presenting the reports to the appropriate team, committee, and/or manager.

- All self-inspection reports and correction activities will be reviewed by the appropriate team, committee, and/or manager, and noted in meeting documentation. The safety officer will report the results of the self-inspections, follow-up activities, and their recommendations for improvements to the appropriate team, committee, and/or manager to ensure the organization utilizes the information to increase the level of safety throughout its operations.

- The Safety Officer will maintain a record of all inspection documentation and reports, including recommendations and corrections made, and all meeting minutes that correspond with the specific inspection and resulting improvement activities.

- The Safety Officer will be responsible for the following emergency preparedness activities:

    1) Conducting and/or coordinating all required emergency drills

    2) Conducting drills in a manner and with the necessary precautions to not unduly disturb persons served or the ongoing provision of services.

    3) Completing the appropriate Emergency Drill Reporting Form.

4) Educating and informing staff members following drills as to response patterns and improvements in responses.

5) Reporting the results of emergency drills and providing a copy of each report to the appropriate team, committee, and/or manager.

6) Utilizing management team recommendations and decisions, based on the drill reports, to improve safety at the clinics.

7) Maintaining a record of all drills at each site in the safety book/binder.

- The Safety Officer will provide and/or coordinate initial and ongoing health and safety training for all employees. Within this role, cooperation with the organization's Human Resource and/or Training designee will support development of training materials, protocols, and documentation of completed safety orientation or ongoing safety training.

- The Safety Officer will receive training, supported by the organization, based on the assessed safety needs of the organization and the safety educational needs of the individual responsible for organizational safety.

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Assertive Community Recovery, LLC

COMMUNITY-BASED SERVICES SAFETY MANUAL

Manual 09.20

INDEX

Introduction

Safety is of paramount importance in community-based services. It is important to do what we can to minimize risks to our clients as well as ourselves. Over the years we've become more aware of on-the-job risks to ourselves and the day-to-day living risks to our clients. We've also become aware of risks to us involved in getting to and from our client's homes and schools. This manual is an overview of safety/risk issues. It is a response to the broadest range of risks that we could encounter. Some are very unlikely to occur, yet we have included some unlikely items because they have been known to occur and we want community-based human service workers to be prepared.

Please read this safety manual and, as you are reading it, remember that our employees are not expected to take undue risks. If the risk to you appears to be high, it is a good idea to consult with your supervisor and do whatever you need to do in order to maintain your safety. It is always important to trust your instinct. If you have a "feeling" that something isn't right, act on your instinct and maintain a cautious and conservative approach to the situation.

This manual is intended to be a resource for maintaining your safety in community-based care. Please read it carefully and always make safety a priority in your daily activities.

APPROACHING THE HOME

1. As you approach the home, note:
   Location of doors and windows
   Are any neighbors around?

2. Listen before you knock or ring doorbell.

3. Adapt your eyes to light conditions inside the home.

4. Stand to the side of the door-someone may come out quickly.

5. Wait for the client to come to the door to invite you in.

6. Don't walk in if the door is open.

7. Don't walk in if a voice calls out "come in" and you can't see anyone.

ENTERING THE HOME

1. Choose a "safe place" to sit.

2. Leave yourself an exit; sit near a door.

3. It is best to have your back to a wall.

4. Living rooms are the safest places to meet.

5. Bedrooms are where most guns are kept.

6. Kitchens are full of all kinds of potential weapons.

7. If possible, leave the door open.

8. When meeting in inside rooms, it is especially important to leave the door open.

WHEN IN THE FAMILY'S HOME

1. Notice exits and possible escape routes.
2. Sit nearest the door, if possible
3. Sit with your back to the wall.
4. If you feel unsafe, be alert for physical cues signaling danger.
5. At all costs, avoid confrontations:
    a. Be respectful, calm, and agreeable.
    b. Leave or change directions in the conversation.
    c. Go to a safety spot (car, room with other family member, outside, neighbors).
    d. Call supervisor and/or police if situation warrants and allows.
    e. Have the address of client's home available or memorized.
6. Carry an I.D. at all times on your person.
7. If police raid the client's home while you are there:
    a. Stay as calm as possible.
    b. Do exactly what the police say.
    c. Don't reach in pockets/purse/or briefcase for I.D.
    d. Establish who you are later, when things are calm.

IN YOUR CAR

1. Keep your car mechanically maintained.
2. Know how to change a tire.
3. Carry a can of tire sealant
4. Make sure your spare tire is full

5. Make sure your trunk is equipped with a flashlight, blanket, city map, and jumper cables.

6. Make sure your gas tank is not low.

7. Lock car doors when in car.

8. Stay on main roads in urban areas-especially in poor weather, late at night, or when having car trouble.

9. In rural areas, choose roads you think will maximize the chance you will be helped if your car breaks down.

10. Keep quarters in you car for phone calls or carry a cellular phone.

11. Know where you are going.

12. Take care of personal needs (going to the bathroom) before leaving.

13. Ride around the client's neighborhood and check for safety spots (stores, gas stations, etc.)

14. Have the number of emergency road service in your car.

TO AND FROM YOUR CAR

1. Drive around the neighborhood. Note potential dangers such as abandoned buildings, dark streets, noises of fighting, congregations of people indicating gang values or transactions, gang graffiti, drug evidence on the ground, substance impaired persons.

2. Park your car under a light.

3. Do a "360" look around, to and from your car.

4. Have car keys in hand/available.

5. Leave thoughts of the client/family in the car-once you leave the car, focus all of your attention on the surroundings and be alert.

6. Because driving while preoccupied can be dangerous, after an upsetting and/or difficult session, find a safe spot and call to debrief with your supervisor prior to driving home.

7. If the client is not at home, assess the risk of waiting in your car versus going to a safe spot to wait and call the client.

8. Go to a safe spot to write notes and/or use cellular phone after sessions.

9. Ask family members to watch you as you go to your car after dark.

10. Don't go to your car if someone is hanging around it-seek assistance or someone to accompany you.

11. If you suspect you are being followed, drive to the nearest safety spot to get help-don't drive home and possibly provide your home address to someone following you.

12. If being followed:

    a. Take the time to observe the vehicle and occupants for descriptions. Stay calm.

    b. Note the direction the vehicle travels when you reach a safety spot to call for help.

13. Look in you back seat before getting in you car (even if you locked it!).

14. If your car dies, breaks down, or you are in an accident:

    a. Pull to the right side of the road, if possible.

    b. Put flashers on.

    c. Open hood.

    d. Get back in the car, lock doors.

    e. Call for assistance, if you have a cellular phone, ask someone to call a wrecker, spouse, or a friend if you don't.

    f. While waiting for assistance, review self-protection strategies.

    g. Talk through the open window only.

h. Don't accept rides without considering the risks to you personal safety.

i. If you leave your car for assistance, leave the car door unlocked so you can re-enter quickly, if needed.

j. Observe the person offering assistance (smell of alcohol, other cues you may be unsafe?).

k. Check out the person's car who is offering assistance. Is there more than one occupant in the car? Is anyone in the back seat? Are the car handles present on the inside of the door? Trust your gut feelings to turn down a ride. Embarrassment has no place when considering your safety.

15. Don't ask a group of people on the street for directions.

WHEN WALKING

1. Walk fast.
2. Stay on main streets.
3. Face traffic.
4. Don't carry a purse, if possible, or carry it close to your body.
5. Don't carry charge cards.
6. Carry quarters if you don't have a cellular phone.
7. Note safety spots along the way.
8. Be alert, look around, and keep head up while walking.
9. If you sense danger and/or feel unsafe, leave immediately, change directions, got to a safety spot and/or your car.
10. Don't ask groups of people for help or directions.

PRIOR EPISODES OF VIOLENCE TOWARD PEOPLE OUTSIDE THE FAMILY

Initial phone call:

1. Allow plenty of time for the conversation. Use lots of active listening.
2. Talk to the allegedly violent person and try to establish a relationship.
3. Assess whether clients are escalated. If so, use active listening.
4. Ask a family member for their assessment of the potential for violence.
5. Assess whether there are any weapons in the house.
6. If you are still concerned about the potential of violence, consider meeting with the most approachable family members.
7. Ask family members to lock up or remove all weapons.
8. Consider meeting in a neutral place.

Preparation for first session:

1. Call the referring worker for more information.
2. Notify your supervisor of you initial phone call assessment.
3. Notify a supervisor/co-worker of where and when the first session will take place. If necessary, develop a plan of when you will call to confirm your safety including code words or a plan of action if no call is received. If a cellular phone is an option, file the number to the supervisor and keep the phone on.
4. Consider taking your supervisor or a co-therapist with you.

During the first session:

1. Drive around the neighborhood to get your bearings and locate aids and safety spots.
2. Park as close as possible to the home so that accessing your car and leaving is easy.

3. Keep calm, relax, take a deep breath, and use self-talk such as “It is not my responsibility to change this person.”

4. Keep your car keys readily accessible such as in your pocket.

5. As you approach the home, note the location of exits, including window.

6. Listen before you knock.

7. Stand to the side of the door.

8. Wait for the client to come to the door.

9. Choose a “safe place” to sit unless the family directs the seating arrangement.

    a. Try to sit near the exit with your back to the wall.

    b. Living rooms are safer than bedrooms or kitchens where weapons can be stored or where potential weapons exist.

    c. If possible, leave a door open.

    d. Think out an escape route.

10. Observe the home for potential weapons.

11. Be alert to household members’ physical cues of escalation, e.g., facial expressions, muscle tension, posture, breathing, complexion changes.

12. Respect the family’s personal space. Don’t crowd them or touch them.

13. Ask the clients’ permission-check out everything you do.

14. Meet separately with each family member, if appropriate or necessary.

15. Talk with the most upset person first.

16. If the situation begins to escalate, de-escalate it by giving away your power, e.g., stop teaching, problem solving, or directing and go into active listening mode.

17. Additional options to de-escalate:

    a. Distract the issue with creative time-outs, e.g., requesting to go to the bathroom.

b. State your concerns using "I" messages including consequences for use of violence.

c. Consider relocating to a neutral location with one person or more.

d. Leave if you feel in personal danger.

e. Call your supervisor from a phone in a safe location, as soon as possible.

YOUR CLIENT LIVES IN AN UNSAFE NEIGHBORHOOD

1. Discuss with your client the safest time to meet.

    a. Consider meeting in a safer location.

    b. Ask if they will watch the street for your arrival.

    c. Meet during the daylight hours, especially during initial visits.

2. Let your supervisor know your route and destination address and when you anticipate your return home. Develop a check-in contingency plan.

3. On the way, get your bearings or locate aids/safety spots.

4. Travel main streets as much as possible.

5. Leave the area immediately if it appears too dangerous; call your supervisor from a safe phone or cell phone.

6. Park close to the client's home, ensuring easy access to the car and an easy drive out.

7. Keep alert and on the lookout when walking to and from the home.

    a. Leave your purse and jewelry in the trunk or at home.

    b. Have the car door key in your grasp.

    c. Walk erect and briskly.

d. When leaving the home, ask someone to walk you to the car or to watch while you get into your car.

8. Take a cellular phone, if available. Try not to use it in a dangerous neighborhood in order to decrease the possibility that observers misunderstand your job or so observers won't decide they want the phone.

SINGLE PARENT WITH A JEALOUS PARTNER WHO HAS A HISTORY OF VIOLENCE

1. Sit near an exit.

2. Let the client know that you think the partner is there: "Do you think ( ) would like to join us or would you like to reschedule?" "May I meet ( ).

3. Be careful of your words and how actively listen, e.g., limit complements or levity, be more reserved, reflect primarily content or those feelings actually verbalized-especially if the topic involves the partner. Avoid validating complaints, negative observations about the partner or making inferences.

4. Try to engage the partner.

5. Try to normalize hesitation to meet or examine possible blockages, e.g., "I can understand how hard it might be to meet with someone who you have no reason to trust."

6. Discuss the situation with your supervisor-brainstorm options.

DURING A SESSION, PHYSICAL VIOLENCE IS THREATENED TOWARD A FAMILY MEMBER

1. If, over the phone, there appears to be a potential for physical violence, ask family members to avoid "hot topics" until you arrive and/or ask family members to wait in separate rooms.

2. When violence is threatened during the session, stop what you have been doing and go into active listening mode. Now is not a time for problem solving, reframing, or pointing out irrational thinking.

3. Use "I" messages regarding your concern about the potential for someone getting hurt.

4. Use their names when talking or reflecting.

5. Model calmness in your voice and movements-deep breathe if you are becoming anxious.

6. Think out loud: "It seems like everyone needs some space right now. Maybe we could all use a time out."

7. Attempt to distract the individual:

    a. Stand up and say the individual's name in a loud voice.

    b. Consider if it might be helpful to make a distracting noise-drop books, make a beeper go off.

    c. Send a family member into the kitchen for a glass of water for you.

    d. Ask if they could separate while you consult with your supervisor on the phone.

    e. Tell them that what they are saying is so important that you want to write down a list of their issues.

9. Talk to the most upset person first-consider taking them for a walk to a neutral location if they are willing and if you think it would be safe.

10. Take the other family member(s) away from the situation if the family member(s) think it's safe to leave the individual.

11. If possible, help the person structure the interim time to facilitate calming.

12. Leave if you assess that your presence is escalating the individual of if you believe the situation will improve if you do.

13. Leave if a family member is telling you to.

14. Arrange a time you will make a check-in call, if appropriate.

<u>If you fear that the parent will subsequently harm the child after you leave</u>:

1. Use an "I" message to state your need to arrange a time-out placement and call the referral worker as appropriate.

2. Call your supervisor as soon as possible from a phone in a safe location.

3. If you believe a family member is in immediate physical danger and you are unable to separate family members, leave the home and call the police before calling your supervisor. Use an "I" message to tell the family of your need to call the police only if you think it would not escalate matter to say so.

<u>If a weapon is involved:</u>

1. Try to get the person to voluntarily put the weapon down-preferably put away in another room or locked in the trunk of a car.

2. Do not try to physically take the weapon from the person.

3. If the person refuses to put down the weapon, request to leave, to call your supervisor if you are not permitted to leave, or to take the person our for a drink/coffee of all attempts to leave fail.

4. If the person refuses to put down the weapon but allows you to leave, call police from the nearest phone before calling your supervisor.

5. Use "I" messages to present alternative behaviors.

6. Try to eliminate challenges or control issues.

7. Model and/or suggest peaceful alternatives and reinforced family members doing the same.

8. Use "I" messages to propose consequences of someone getting hurt.

9. If the weapon is locked away and is no longer an issue, follow other guidelines for threat of physical violence against family members.

10. Debrief incident with supervisor from the nearest phone in a safe location after leaving family.

11. Debrief the incident with team members in the next staff meeting or case consultation.

<u>After the crisis passes and physical violence is no longer threatened</u>:

1. Help the family remove or secure weapons or potential weapons.

2. Help individual family members structure activities which reduce likelihood of conflict, e.g., child staying overnight with a friend, adult engaging in a leisure activity, etc.

3. Encourage family members to stay away from "hot" topics until you have a chance to work further with them.

4. Schedule telephone check-ins between sessions.

ANGRY PARENT THAT HAS JUST HURT THEIR CHILD

1. If the injuries need medical attention, call 911.

2. Use lots of active listening.

3. If you think it is safe for the child and yourself, use an "I" message to state your obligation to contact the referral worker and give the parent the opportunity to report first.

4. If you do not think it is safe to discuss a (fill in required reporting mechanism) report in the presence of the parent, call your supervisor from a phone in a safe location.

5. Before leaving the home, help the individual parent or child reduce the likelihood of conflict by:

    a. Structuring activities such as the child staying overnight with a friend (or in receiving home care), the parent engaging in a leisure activity, etc.

    b. Encouraging the family members to stay away from "hot" topics until you have a chance to work further with them.

    c. Helping the parent(s) identify calming self-talk and contract to call you when he/she feels the beginnings of escalation.

    d. Schedule telephone check-ins between sessions.

6. If you do not think it is safe to leave the home with the child still there:

    a. Arrange to have the child relocated to a safe place or to go with you and call your supervisor from a phone in a safe location.

b. If the parent will not permit the child to leave or be taken out of the home by a family member nor permit you to leave with the child, call your supervisor from the home (Begin your contact with your supervisor with "I am calling from the home of _____").

c. If the parent will not permit you to call from the home and if you do not think it will further escalate matters, use "I" messages to state your concerns and the consequences of having to leave the home without being able to ensure the safety of the child, e.g., "I am very worried because you've been having a very difficult time and that something might happen again that results in Billy being hurt. If I can't take Billy with me while I consult my supervisor and you won't let me call my supervisor from the home, my agency's policy requires me to call the police.

7. If you still have to leave the child:

a. Call the police (911) from the nearest phone to express your concerns. If you feel unsafe, consider asking the police to meet you to accompany you back to the home.

b. Return to the home if you are reasonably sure you are safe. If there's some doubt, consult with your supervisor first.

c. If returning to the home is unwise, call the parent from a nearby telephone and attempt to keep him/her occupied.

d. Call your supervisor as soon as possible.

UNKNOWN PEOPLE IN AND OUT, DRUG USE IS SUSPECTED AND WEAPONS MAY BE PRESENT

1. Using "I" messages, discuss concerns with the client: "I am concerned that so many interruptions may not be helpful to our work together. I don't feel comfortable with people coming and going. Is there another time we could schedule a meeting that might be more private?"

2. Discuss with the client your concerns regarding drugs and/or their substance use. Attempt to actively listen to the client's concerns.

3. If the situation appears to be escalating, either because of your concerns of some external element in the home, LEAVE. If children are present, request

permission to have a session with the children so you can remove them from danger.

4. From a safe phone, consult with your supervisor.

5. Prior to the next session, explore whether weapons are in the home and negotiate a secure plan, meet outside the home, or meet at a safer time.

6. If weapons are present in the home, review weapons section of this manual.

7. If the clients talks about feeling unsafe with the people in the home:

    a. Determine whether the client feels safe. If not, relocate to a safer place.

    b. Mentally review your self-protection skills.

    c. Help identify escape routes.

    d. Have sessions at safer times or outside the home.

    e. Determine the pattern of traffic, e.g., time of day, entrances, relationships, etc.

    f. Help the client get a phone if they don't have one.

    g. Help identify safe neighbors and get to know the neighbors yourself.

    h. Help the client develop a safety plan.

    i. Help the client get a self-protection device.

    j. Discuss with client options regarding moving.

    k. Consult with your supervisor and team.

YOU FIND CHILD HOME, BUT NO PARENT

INTAKE: Finds children under the age of 12 present put no parent.

1. Do not enter home even if the children invite you in, unless the children are so young that you fear for their safety if left unattended.

2. Inquire as to whether the parents had left a message for you with the children, e.g., they called and said they would be ten minutes late or they just stepped out for a couple of errands.

3. Inquire as to how long parents have been gone and kids have been alone.

4. See if the children have a number to call for supervision, e.g., aunt, grandmother, neighbors. Have them call and request someone to supervise them.

5. Assuming the children are old enough to be safely in the home, wait in the car 30 minutes for the parents to arrive. If no show, call and inform your supervisor.

6. If no one can watch the kids and there's no indication of when the parent(s) will return, call DFCS and request possible emergency placement.

REGULAR SESSION: Ongoing relationship with family, but finds children under age of 12 with no parent.

1. Consider the risks of entering the home. Weigh questions like whether you expected parents to be gone, whether danger is present for the child. It cam be risky to be in the home without another adult present.

2. Inquire as to whether parents had left a message for you with the children.

3. Inquire as to how long the parents have been gone and the kids have been alone.

4. Take the child to a public place for the session if your agreement with the parent allows for this. Be sure to leave a note for parents including the exact time you'll return. Without prior permission to take the child away from the home for this session, meet on the front porch.

5. When the parents return, address your concerns regarding the child's safety. Assess the child's ability to refuse to answer the door for strangers; ability to call 911; other supervision resources; the child's ability to follow emergency

procedures; the child's compliance regarding non-use of oven or other potentially dangerous appliances.

6. Work with the parents to develop a more comprehensive childcare plan if this situation is routine.

7. If the children are very young, consult with your supervisor; report, if necessary, to family services, and/or inform the family of the mandate to report them.

WHEN WEAPONS ARE PRESENT IN THE HOME

1. Discuss with the referring worker whether there have been past reports of violence.

2. Gather information from family members regarding their numbers, use, and storage condition.

3. Consult with your supervisor.

<u>If there are past reports of violence and you feel uncomfortable.</u>

1. Use "I" messages to express your concerns.

2. Provide the client with alternatives such as:

    a. Removing the pin from the gun.

    b. Keeping the weapon in a different room.

    c. Keeping the gun in the trunk of their car—even if just during sessions.

    d. Utilizing the police's safe-keeping storage for the gun.

    e. Having a family member monitor mood changes of the person with the weapon and checking by telephone with the family member before going to the home.

    f. Asking the client to come to the door unarmed.

3. Consider meeting outside the home if the client refuses to reconsider his weapon storage.

4. If an option, carry a cellular phone.

If there are past reports of violence and someone appears impaired.

1. Meet outside the home.
2. Reschedule session.
3. If you are concerned for the safety of other family members, use an "I" message to express your concerns.
4. Discuss a temporary weapon-storage plan and/or possibility of children staying overnight at a friend's homes.
5. If you need to leave and are still concerned regarding the safety of family members, arrange a telephone check-in.
6. Consult with your supervisor from a phone in a safe location.

IMMEDIATE RISK OF SUICIDE

1. Stay calm/assess your own safety.
2. Use "I" messages: I'm concerned, I care, I'm taking this seriously.
3. Talk to the person about his/her thoughts/plans.
4. Unless you feel your own safety is in jeopardy, stay with the suicidal person as much as possible.
5. Get help from family members to structure environment (hide car keys, knives, pills, weapons).
6. Continue to talk, show interest and support.
7. Reflect feelings, discuss and emphasize the client's cognitive inhibitors that decrease the risk of suicidal behaviors (Against religious beliefs, etc…).
8. Try to contract a safety plan five minutes at a time until help arrives.
9. Call someone the client feels is a support like immediate family members or clergy.
10. Consult with your supervisor.

11. If the client refused all help, call the agency responsible for emergency hospitalization in your area for next steps. If you can't get advice from this agency, call 911.

If an adolescent is at risk of suicide:

1. Same as above.
2. Talk with your supervisor to assess your need to tell the parents.
3. Dispel myths with the parents (see below).
4. Review the warning signs with the parents (see below).
5. Get help from people like your supervisor, the child's family, or the referring social worker.

Warning signs:

1. Suicide threats.
2. Statements revealing a desire to die.
3. Previous suicide attempts.
4. Sudden changes in behavior (withdrawal, apathy, moodiness).
5. Depression (crying, sleeplessness, loss of appetite, hopelessness).
6. Final arrangements (giving away personal possessions).

Myths:

1. People who talk about suicide don't really do it.
2. Talking about suicide encourages it.
3. Only a certain type of person commits suicide.
4. Suicide is a lower class phenomenon or occurs in only certain ethnic groups.
5. Suicide in inherited and run in certain families.
6. Suicidal people are mentally ill.

7. People under a psychiatrist's care rarely commit suicide.

8. An unsuccessful attempt at suicide is not to be taken seriously.

9. When an adolescent attempts suicide or commits suicide, it usually is an impulsive act.

10. If an adolescent has been depressed and the depression starts to lift, he/she is finally out of danger.

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4151 Memorial Drive, STE 209-C
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Vehicle Safety Emergency Policy and Procedures

ACR Policy 09.21 - Transportation of Persons Served Safety Guide

Purpose of the Manual:

It is the goal of ACR to provide a safe working environment for all staff, individuals and visitors.

This booklet is intended to communicate the agency policy and procedures regarding emergencies occurring during the use of agency owned/leased vehicles and the use of staff member's personal vehicles during the provision of services.

Please review this information carefully. Direct any questions or need for clarification to your immediate supervisor. Any input regarding ways to improve our safety procedures is welcomed. Contact the agency Safety Officer with your ideas.

The safety of staff, individuals and visitors is a responsibility shared by all members of our agency's team.

Effective November 8, 2017, ACR staff members are no longer authorized to transport individuals receiving services from ACR in personal owned vehicles at anytime or for any reason. This also includes the family members of the person served.

Individuals/families family members needing transportation will be assisted with identifying and linking with public and private transportation assets to meet their recovery needs. Remember, it is ACR's role to be a treatment provider and not be a transportation service. In providing services to assist individuals in achieving their recovery needs, we have a critical responsibility to link individuals with resources and not be the resource other than that of a treatment provider. **Under no circumstance will a personal owned vehicle be used to transport individuals or their families.** Your supervisor is available to help identify transportation for individuals and their families.

What follows in this guide explains the procedure for transporting individuals in ACR company owned vehicles.

Table of Contents

Standards for Drivers

All staff members must comply with company policies regarding the operation motor vehicles while operating the agency vehicle at anytime or anytime a personal vehicle is used while performing duties for ACR.

This includes:

1. Valid driver's license.
2. No operation of motor vehicles under the influence of alcohol or other drugs.
3. No smoking in agency vehicles.
4. All drivers will complete a basic safety orientation prior to transporting individuals in company vehicles.
5. Employees using motor vehicles (both company and personal owned) while performing work related duties must immediately report any loss or suspension of driver's license, cancellation or termination of personal vehicle insurance, and/or convictions for traffic violations.
6. Should an employee utilize a motor vehicle while carrying out agency business without proper license and insurance, the employee will be subject to dismissal and will assume full legal and financial responsibility for any adverse events that may have occurred.
7. Each employee will produce driving records to this agency upon demand. The CEO, Safety Officer, or designee, will review employee driving records upon hire and not less than every three (3) years thereafter

Documentation Required in the Vehicle

1. Valid driver's license.
2. Vehicle Registration.
3. Staff that use their personal vehicle doing agency work shall have proof of insurance in the vehicle at a minimum of $100,000/$300,000/$100,000 with a business use rider. (Staff cannot transport individuals/families receiving services from ACR in a personal vehicle).
4. A copy of the agency Vehicle Safety Emergency Procedures booklet.
5. All staff in the vehicle will have an identification badge.
6. A phone directory containing numbers for the agency and emergency services in the area.

Safety Equipment

All vehicles used in the transportation of individuals will contain:

1. Jumper cables.
2. First Aid kit.
3. Seat belts for all passengers.
4. Cell phone.
5. Triangular emergency reflector
6. S spare tire, jack and appropriate tools for changing tires.

Equipment Failures, Flat Tires, etc.

1. All vehicles transporting individuals will have a functioning spare tire, jack and appropriate tools for changing tires.
2. In event of flat tire or engine failure:
    a. Immediately pull to a safe location on the shoulder of the road, out of traffic.
    b. Place the triangular emergency reflector behind the vehicle to warn oncoming traffic.
    c. Notify your supervisor by cell phone.
    d. Assist the individuals in moving to a safe location, if appropriate.
    e. Make repairs as possible, or call for emergency roadside assistance.
    f. Contact your supervisor for additional transportation for individuals if repairs are not immediately achievable.
    g. Complete a Critical Incident Report.

Limiting Distractions

Federal safety research indicates that visual and cognitive distractions contribute to the majority of auto accidents. To reduce distractions:

1. Do not Text and Drive.
2. Do not talk on handheld cell phones while driving. Pull to the side of the road to talk or have a co-worker in the vehicle handle the call.
3. Resist the temptation to be distracted at the scene of accident sites.
4. Avoid staring at pedestrians or other drivers. This behavior is cited by the national transportation safety board as a significant cause of auto accidents.
5. Do not eat or drink while transporting individuals.
6. Do not read or attempt to write while driving.
7. Do not wear headphones while driving.

Effective July 1, 2018, it is illegal in Georgia for drivers to "physically hold or support, with any part of his or her body," a wireless telecommunications device. Georgia law makes it illegal for drivers to make and receive telephone calls, send and receive text messages or emails, post on social media, or browse the internet with a hand-held device while driving (including while stopped at a traffic light). Drivers must use an earpiece or wireless device, including a smartphone watch, for making calls, sending or receiving texts, or for navigational purposes. **(**"Hands-Free Georgia Act", House Bill 673)

Disruptive / Combative Passengers

1. If a passenger becomes disruptive or combative, pull to the side of the road immediately.
2. Place the vehicle in Park, set the brake and turn off the ignition.
3. Use verbal de-escalation techniques appropriate to the individual.
4. It is often helpful to remove other passengers from the vehicle to limit peer support for inappropriate behavior, reduce escalation of peers by the passenger acting out, and reduce the number of targets available in the case of violence.
5. Do not proceed with travel until the situation is well under control and no longer poses a threat to the safe operation of the vehicle.
6. If the situation escalates, dial 911 and ask for immediate assistance.
7. Assist emergency personnel as appropriate.
8. Notify your immediate supervisor as soon as the situation allows.
9. Complete a Critical Incident Report

Accidents without Injuries

1. Immediately check with all passengers and the occupants of any other vehicles to determine if anyone is injured. If there are none reported, proceed with the following steps.
2. Notify your supervisor immediately. Additional staff and transportation will be sent to aid in caring for individuals as appropriate.
3. Make no statements regarding fault for the accident.
4. Call the police and report the accident.
5. Exchange information with the driver of any other vehicle involved including name, address, phone #, driver's license #, and insurance information.
6. Collect the names and phone #'s of any witnesses available.
7. Notify your supervisor when ready to proceed with the day as planned.
8. Complete a Critical Incident Report

Accidents with Injuries

Follow the directions above with the following exceptions:

1. Call 911 immediately for assistance.
2. Do not attempt to move injured individuals.
3. When emergency personnel arrive, assist as requested.

Other Medical Emergencies

1. A medical emergency is defined as an incident that requires interventions beyond simple first aid available at the facility to stabilize a condition that may result in a serious medical outcome. Conditions include, but are not limited to, excessive bleeding which is unable to be controlled, accidents involving serious injury, failure or obstruction of the respiratory system, failure of the circulatory system, chest pain or severe abdominal pain, loss of consciousness unrelated to predictable seizure activity, or any type of distress that is determined to seriously limit an individual's normal level of daily functioning.
2. When an event occurs that is determined to be an emergency health care incident, 911 will be immediately called to access emergency personnel to assist and transport the individual to medical services.
3. Notify your supervisor as soon as possible. Additional staff will be sent to assist in the care of individuals and transportation as appropriate.
4. Staff members who are trained and hold current certification in CPR and First Aid will implement CPR and/or First Aid procedures, when appropriate, to stabilize a condition prior to the arrival of external emergency personnel.
5. Following containment of the emergency, a progress note will be completed in the record of the person served and a Critical Incident Report form will be completed.

Transporting Individuals to Higher Levels of Care

When it is determined that local services are not available to transport the individual to a higher level of care, the individual is **agreeable** to the transfer, and staff has assessed that the potential is minimal for assault or violent behavior on the part of the individual, the following guidelines will be followed:

1. Three staff members who have appropriate training will be designated by the treatment team leader to transport the individual.
2. The individual's therapist, along with the team members will meet with the individual and provide information about how the transfer will proceed.
3. The individual will be transferred in an employee's vehicle and placed in the backseat of the vehicle.
4. An employee will sit on each side of the individual in the back seat.
5. The driver of the vehicle will carry a cell phone programmed to contact the local police.
6. If the individual, at any time, threatens physical violence or becomes violent, the driver will immediately pull to the side of the road, contact the police, provide location, and inform them of the emergency
7. Employees sitting with the individual in the vehicle will use emergency restraint practices consistent with the agency emergency restraint policy until the police arrive.
8. Following contact with the police, the driver will assist with the restraint.
9. Upon arrival of the law enforcement, employees will release the individual to the custody of the officers.

In situations where the individual is **not agreeable** to a transfer to a higher level of care, all legal procedures have been met to initiate the transfer, and it is reasonably determined, by behavioral observation, that the individual will physically resist the transfer, the following guidelines will be followed:

1. Contact will be made with the local police to request on-site assistance, with the transfer. The police will be informed that physical violence has been threatened and it is expected that physical assault will occur.
2. Employees will be responsible to assist in de-escalating any potential behavioral emergency prior to the arrival of emergency transport personnel, such as the local police.
3. The individual's therapist, or designated staff member, will meet with emergency personnel upon arrival and apprise them of the situation prior to them entering the facility. Confidentiality law allows specific individual information to be relayed to emergency personnel in lieu of a release of information.
4. The general area in which the custody will take place will be cleared of individuals until the transfer is completed.
5. If the transfer of the individual results in any behavioral disruption within the program areas, employees will assess possible effects such disruption may have on program individuals. Appropriate therapeutic interventions will be instituted should the nature of the disturbance be determined to warrant such action.

Agency Phone #'s:

(404) 508-0078

Emergency On-Call Phone (678)

499-8695

Local Emergency Phone #'s:

911

Georgia State Patrol

(404) 624-6077

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

09.22 - Sharps and Biohazardous Waste Procedures

I. POLICY:

A. It is the policy of ACR to ensure the safe disposal of sharps and biohazardous waste to protect employees, individuals serve and the public by following all local, state and federal rules and regulations governing the disposal of such waste.

B. Definitions: Biohazardous/Infectious Waste materials at ACR Health Services are identified:

1) **Biohazard waste:** Also called infectious waste or biomedical waste, is any waste containing infections material or potentially infectious material.

2) **Microbial waste:** Laboratory wastes containing infectious agents. Examples are discarded specimen cultures, blood or body fluids known to contain infectious pathogens. Discarded live and attenuated vaccines.

3) **Pathological waste:** Laboratory specimens of blood and tissue, foreign/body implantable material such as surgical implanted devices or medication dispensing devices, and materials removed during surgery, biopsy or birth.

4) **Human blood or blood products:** Human blood or blood products (such as serum, plasma and other blood components) in liquid or semi-liquid form.

5) **Human body fluids (other potentially infectious fluids):** Human body fluids in a liquid or semi-liquid state, including semen, vaginal secretions, synovial fluid, amniotic fluid, saliva from dental procedures as well as cerebral spinal, pleural, pericardial or peritoneal fluids that are visibly contaminated with blood OR are impossible to differentiate between body fluids.

6) **Sharps:** Clean OR contaminated objects that can that may cause punctures or cuts. Such waste includes, but is not limited to, items such as needles, IV tubing and syringes with needles attached, and scalpel blades.

C. The Quality and Compliance Officer is responsible for ensuring that the procedures in this policy are followed and met.

II. PROCEDURES:

A. **Training:** Each new health care worker will receive an in-depth orientation in the procedure for the in-house collection, transportation, and/or storage of infectious waste. Continual in service training will be provided to such employee by their supervisor.

B. **Management of Biohazardous Waste and/or Infectious Material** occurs through use of:

1) PPE (Personal Protection Equipment) such as gloves, gowns, goggles as necessary, to ensure highest degree of safety possible.
2) Puncture Proof Waste Cans Identified as Biohazard Waste Cans

3) Biohazard Red Bags to line Biohazard Waste Cans and Biohazard Boxes.
4) Biohazard Boxes used to store biohazard trash bags.
5) Lab Specimen bags labeled biohazard.
6) Sharps containers.

C. Storage and Disposal of Biohazardous and Infectious Waste

1) **Sharp objects** used to collect labs (needles, lancets) or sharp objects contaminated with biohazardous/potentially infectious material in the process of collecting labs (pipettes, blood culture tubes, microscope slides) are to be placed in SHARPS containers.
2) **Sharps containers** are to be sealed and placed in Waste Boxes (Maintained in 'dirty' storage closets) whenever fill line is reached (2/3 full).
3) **Instruments contaminated with blood or body fluids** are to be placed in a designated metal basin containing 1 cap of detergent and water in the amount that instruments are covered. Instruments are then cleaned by autoclave process.
4) **Dressings or bandages saturated with blood or body fluids known to be infectious** are to be placed in biohazard waste cans located in each patient clinic exam room. New biohazard liners are to be placed in trash daily. Biohazard bags containing biohazard or infectious material are to be placed in the Waste Box located in the 'dirty' storage closet. (Bags when full, should not weigh more than 25 pounds).
5) **Biohazard Waste Boxes:**
   a. Are to be lined with biohazard red bags
   b. Biohazard red bags in waste boxes are to be closed using a hand knot when the box is full.

   c. Boxes must not be full to where lid does not close easily.
   d. Additionally, biohazard boxes are to be sealed (taped close) when full.
   e. Will be picked up by Steri-Cycle as scheduled by ACR's Quality Assurance and Compliance Director. To schedule an additonal pickup or for service related questions, Steri-Cycle can be contacted at 1-866-783-74r22.

6) **GOWNS and GLOVES** and any material that is NOT SHARP and NOT SATURATED with blood or other infectious material is to be disposed of in regular waste containers.
7) **Urine and feces** can be flushed directly into the sewer system.
8) **OSHA protocols** are to be followed. Staff are to wear gloves and adhere to hand sanitizing procedures when handling hazardous materials, red bags, or waste boxes.

D. **Surfaces contaminated with spills or leaked biohazardous waste** shall be cleaned using a spill kit or industrial strength detergent to remove visible soil and shall be disinfected with one of the following chemical disinfectants at the minimum concentration levels:

1) Freshly prepared solution of household bleach, diluted one part to ten parts water.
2) Chemical germicide that is registered by the Environmental Protection Agency as hospital disinfectants for HIV, HBV, and HCV are effective when used at the recommended dilutions.

E. **Health and Safety rounds** (performed daily by clinic staff, monthly by the Health and Safety Officer are utilized to assess risk, safety of the environment and staff compliance with procedures and regulations pertaining to storage, use, and disposal of hazardous materials, wastes and sharps.
F. **Violations of procedures and non-compliance** with regulatory standards are immediately reported to Quality Assurance and Compliance Director and corrected.

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4151 Memorial Drive, STE 209-C
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Policy 9.23 - Handling Combative Individuals

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to:

A. Provide training and guidance to staff in handling combative individuals to ensure staff shall be trained to protect a combative Individual from hurting himself or others or from destroying property in all of Assertive Community Recovery's programs.

B. Not to use any kind of seclusion or restraint as a behavioral intervention in the course of treatment for any individual. The organizational safety policy on violent and aggressive behavior, which directs staff to summon external law enforcement personnel, is followed in behavioral emergencies; however when verbal de-escalation has failed **only those techniques taught in the approved CPI Nonviolent Crisis Intervention training and only by employees who have completed CPI training and are judged by the organization as qualified.**

II. PROCEDURES:

C. All direct care staff will receive annual training in Physical Crisis Interventions (currently based on Crisis Prevention Institute-CPI model) which includes verbal techniques for the purpose of de-escalation and safe physical management of Individuals.

D. The staff member will notify the secretary or closest staff person as soon as a potentially combative Individual is recognized.

E. The secretary notifies the case manager and/or supervisor.

F. The clinical coordinator, program director, or a mental health professional is also notified.

G. If an individual becomes combative in a public area (such as the waiting room), the case manager shall attempt to have the Individual go to the closest empty office. Staff should use the largest room with the least furnishings available. If other Individuals can be removed, the waiting room is suitable.

H. If the combative Individual cannot be removed from public area peacefully, then staff shall instruct all other Individuals to leave the immediate area.

I. Once the combative Individual is isolated from other Individuals, the case manager makes every effort to talk calmly to Individual assuring them that they are safe

and no one is going to harm them. Family members, if available, may be used to offer reassurance.

J. If combative Individual is in a small room, the door remains open with the Individual having access to the door to avoid feeling "boxed" in. The case manager directs other staff as to whether assistance is needed outside the room or whether availability outside the room is best.

K. If combative Individual makes an effort to attack or throw things at staff members or other Individuals, the staff member and/or Individual(s) exit quickly leaving the Individual alone in the room with the door open.

L. If the combative Individual is destructive to property or leaves the room in an effort to attack staff or Individuals, the local Police Department should be called by the secretary. If possible, the outside doors should be locked to prevent Individual from running into the street.

M. While waiting for the police, the case manager should continue to try to calm the Individual, and encourage the individual, if necessary, walk up and down the halls or around the room as a way of releasing energy without harming anyone.

N. If it is determined the Individual is a danger to self or others, a referral to the Crisis Stabilization Program may be considered.

O. If two individuals become combative with each other, staff should follow the above alert procedures, summon the appropriate clinical staff, and try to persuade the least agitated Individual to back off. At no time should staff try to come between two combative Individuals nor should they allow other Individual to intervene. If neither Individual can be persuaded to back off, then the police should be called and the above precautions taken.

P. If an individual or two individuals become combative in group session, the therapist removes other Individuals from the room and calls for assistance so that above procedures can be implemented.

Q. If the police come, the case manager in consultation with clinical coordinator or mental health professional, determine if in-patient psychiatric evaluation is needed or whether the legal authorities are to be contacted.

R. The case manager will make clinical recommendations to the police officer and expedite implementation by telephone calls to appropriate facility.

S. If the Individual is taken into custody by police (regardless of disposition), the responsible guardian or family members are notified by case manager.

T. And incident report should be completed and sent to the Quality Assurance Director the same day or the next working day if the incident occurs late in the

day. The team leader or program manager documents the incident in the chart noting the date and time of the occurrence.

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B. Not to use any kind of seclusion or restraint as a behavioral intervention in the course of treatment for any individual. The organizational safety policy on violent and aggressive behavior, which directs staff to summon external law enforcement personnel, is followed in behavioral emergencies; however when verbal de-escalation has failed **only those techniques taught in the approved CPI Nonviolent Crisis Intervention training and only by employees who have completed CPI training and are judged by the organization as qualified.**

II. PROCEDURES:

C. All direct care staff will receive annual training in Physical Crisis Interventions (currently based on Crisis Prevention Institute-CPI model) which includes verbal techniques for the purpose of de-escalation and safe physical management of Individuals.

D. The staff member will notify the secretary or closest staff person as soon as a potentially combative Individual is recognized.

E. The secretary notifies the case manager and/or supervisor.

F. The clinical coordinator, program director, or a mental health professional is also notified.

G. If a Individual becomes combative in a public area (such as the waiting room), the case manager shall attempt to have the Individual go to the closest empty office. Staff should use the largest room with the least furnishings available. If other Individuals can be removed, the waiting room is suitable.

H. If the combative Individual cannot be removed from public area peacefully, then staff shall instruct all other Individuals to leave the immediate area.

I. Once the combative Individual is isolated from other Individuals, the case manager makes every effort to talk calmly to Individual assuring them that they

are safe and no one is going to harm them. Family members, if available, may be used to offer reassurance.

J. If combative Individual is in a small room, the door remains open with the Individual having access to the door to avoid feeling "boxed" in. The case manager directs other staff as to whether assistance is needed outside the room or whether availability outside the room is best.

K. If combative Individual makes an effort to attack or throw things at staff members or other Individuals, the staff member and/or Individual(s) exit quickly leaving the Individual alone in the room with the door open.

L. If the combative Individual is destructive to property or leaves the room in an effort to attack staff or Individuals, the local Police Department should be called by the secretary. If possible, the outside doors should be locked to prevent Individual from running into the street.

M. While waiting for the police, the case manager should continue to try to calm the Individual, and if necessary, walk up and down the halls or around the room as a way of releasing energy without harming anyone.

   1) If all attempts of verbal de-escalation has been exhausted and the Individual is attempting to harm self or others and a physical hold is necessary, a code green is called and the police will be called immediately.

   2) Only approved staff who have been trained and competent in CPI will participate in a physical hold.

   3) A team leader will assess the situation, have a plan, give direction to the team members, and communicate with the Individual.

   4) The hold will be applied until Individual calms down and can be released or until law enforcement arrives. Staff shall review need for the hold every 15 minutes, not to exceed the hold past 45 minutes. A staff member must be available for ongoing observation of the Individual in the physical hold.

   5) If it is determined the Individual is a danger to self or others, a referral to the Crisis Stabilization Program may be considered.

N. If two Individuals become combative with each other, staff should follow the above alert procedures, summon the appropriate clinical staff, and try to persuade the least agitated Individual to back off. At no time should staff try to come between two combative Individuals nor should they allow other Individual to intervene. If neither Individual can be persuaded to back off, then the police should be called and the above precautions taken.

O. If a Individual or two Individuals become combative in group session, the therapist removes other Individuals from the room and calls for assistance so that above procedures can be implemented.

P. If the police come, the case manager in consultation with clinical coordinator or mental health professional, determine if in-patient psychiatric evaluation is needed or whether the legal authorities are to be contacted.

Q. The case manager will make clinical recommendations to the police officer and expedite implementation by telephone calls to appropriate facility.

R. If the Individual is taken into custody by police (regardless of disposition), the responsible guardian or family members are notified by case manager.

S. And incident report should be completed and sent to the Quality Assurance Director the same day or the next working day if the incident occurs late in the day. The team leader or program manager documents the incident in the chart noting the date and time of the occurrence.

Policy 09.24 - Smoking and Tobacco Use Drugs

POLICY: ACR Health Services (ACR) is committed to providing a safe, healthy, comfortable, and productive atmosphere for staff, persons served, as well as other visitors and therefore; smoking and/or any tobacco products, are **not** permitted anywhere inside the facility, during company time, or at any company-sponsored events.

DEFINITIONS:

"Company property" is defined as all company-owned or leased buildings and surrounding areas such as sidewalks, walkways, driveways, and parking lots under the company's ownership or control. This applies to all company-owned or leased vehicles.

"Smoking or Tobacco" use products are defined as cigarettes, cigars, little cigars, cigarillos, dissolvable products, traditional smokeless tobacco products like chewing tobacco, water pipes (shisha, narghile, argileh, hookah), and electronic cigarettes (vape pen, e-hookah, hookah pen).

PROCEDURES: The Safety Officer or designated staff member is responsible for oversight that will ensure that smoking and/or tobacco use procedures are followed and that any further development, revision, or changes are facilitated through the appropriate process.

A. All forms of smoking and tobacco use are prohibited on company property or during company time. If persons served, staff members, or visitors at the facility do choose to, it must be in designated areas and on personal time. The designated area is at least 10 feet away from all doors and clearly marked. Signage is posted to improve awareness.

B. Designated smoking and/or tobacco areas will be equipped with noncombustible ashtrays.

C. Smoking and/or tobacco use in the presence of persons served or other visitors in a community-based setting is prohibited.

D. The Smoking and/or tobacco use policy and procedure will be communicated through the respective orientation process and visible signage will also be posted.

E. Smoking and/or tobacco use by staff members in unapproved areas may result in disciplinary action.

F. Smoking and/or tobacco use by persons served (or visitors) in unapproved areas will result in verbal counseling. Continued use will result in a violation of the program rules.

G. The sale of smoking products in the organization's facilities is prohibited.

H. The organization will provide, upon request, information regarding the effects of smoking and/or tobacco use as well as resources to support cessation programs.

Policy 09.25 - Drug Overdose Policy & Procedure

OVERVIEW: This document is to provide a prevention, response, reporting, and debriefing protocol for a drug overdose as well as determine a suitable level of action. It is to be utilized by staff in response to drug overdose. While information on overdoses are continually arising, this policy and procedure is evidence-based and exhibits the most recent methods used at time of publication. Changes may be made based on new developments and updated information of resources.

POLICY: It is the policy of ACR Health Services to provide the safest and most current practices when responding to an overdose.

INTENT: To set guidelines for staff to take appropriate action if a consumer is found not breathing, unresponsive, or unconscious due to a suspected overdose.

PROCEDURE: Program Participant safety comes first. Only those who have adequate training should respond in the unlikely event of an overdose on site.

PREVENTION: Education is the first step for preventing an overdose. Knowing what to look for and knowing about available treatment can reduce the risk of an overdose and help survivors attain a healthier life.

1. Staff who are interacting with participants are to be aware of basic behavioral observations that may signal a medical issue.
    a. This may include communication (verbal and nonverbal), speech, dilated pupils, knowledge about current evidence-based practices for the use of pain management, other medication, or illegal drugs, and history of consumer, if applicable.
2. Staff will participate in evidenced-based drug education training to stay current about the basic function of psychotropic medication as well as illegal drugs.

RESPONSE: Staff with current CPR and First Aid Certifications are to respond when notified that a possible overdose has occurred. Staff are to use appropriate personal protective equipment (mouth guard/shield, gloves, etc.) when or if CPR or First Aid must be administered.

WHAT TO DO FOR AN OVERDOSE? The actions and responsibilities of trained personnel include:

1. Try waking the person up by yelling their name and rubbing the middle of the chest hard and put the person on their side so they do not choke.

2. Call 911 right away and give the address and report the status of the person (not breathing, unresponsive, or unconscious).
3. Clear the space of any other unnecessary persons.
4. Request for an additional staff member ("runner") find another certified medical provider to assist.
5. Start CPR or suitable action needed to maintain airflow to person until Emergency Response Team (EMS or Police) arrive.
    a. Make sure nothing is in the person's mouth
    b. Tilt their head back, lift chin, and pinch their nose shut
    c. Give 1 slow breath every 5 seconds until the start breathing
6. Once EMS arrives, they will take over CPR and responsibilities of person.
7. Provide an update to the EMS and other appropriate staff members including any relevant medical or substance use information of person.
8. Collect all names and badge numbers of the paramedics or officers who respond.
9. Complete a Critical Incident Report and debrief with appropriate staff members.

DOCUMENTATION: The following procedures are to be followed in the event of responding to an overdose:

1. Report the Critical Incident to your Direct Supervisor or Agency Director and to other operations, as needed.
2. Complete a Critical Incident Form online via the Accreditation Now online System.
3. Complete any follow up paperwork for the consumer regarding transfer to Detox, Crisis Stabilization, and/or other Treatment including supportive counseling or other referrals.
    a. Every effort should be made for the staff member who was at the scene of the overdose to follow up with the consumer.

AFTER EVENT: Staff health is important to all of us. An overdose is a rare event but can be upsetting. Staff are welcome to check in with one another about the event, debrief using the appropriate resources and support mechanisms, as well as seek outside counseling, if needed.

OVERDOSE HELP AND RESOURCES:

- Poison Control: (800) 222-1222 or https://www.cdc.gov/homeandrecreationalsafety/poisoning/
- National Helpline: (800) 662-HELP (4357) or (800) 487-4889 (TDD, for the hearing impaired)
- Prevent & Protect: https://prevent-protect.org/community-resources-1/

Policy 09.26 - Business Continuity Plan

ACR Health Services has developed a Business Continuity Plan on how we will respond to events that significantly disrupt our business. Since the timing and impact of disasters and disruptions is unpredictable, we will be flexible in responding to actual events as they occur. With that in mind, we are providing you with this information on our business continuity plan.

1. **Contacting Us** – If after a significant business disruption, you cannot contact us as you usually do at **404-508-0078 or ACR_Admin@ACRHealthGA.com**, you should call our alternative number **678-499-8695** or go to our website at **www.ACRHealthGA.com**.
2. Our Business Continuity Plan – We plan to quickly recover and resume business operations after a significant business disruption and respond by safeguarding our employees and property, making a operational assessment, protecting ACR medical records in order to continue to provide necessary services to individuals and families who participate in our programs. In short, our business continuity plan is designed to permit ACR Health Services to resume operations as quickly as possible, given the scope and severity of the significant business disruption.
3. Our business continuity plan addresses: data backup and recovery; all mission critical systems; financial and operational assessments; alternate communications with individuals and families, employees, and regulators; alternate physical location of employees; critical supplier, contractor; regulatory reporting; and assuring our clients continued behavioral health services. In the even that we cannot continue to provide services we will work the Georgia Department of Behavioral Health to refer and assist individuals in transitioning another provider who can meet their needs.
4. ShareNote, our Electronic Medical Records, backs up our important records in a geographically separate area. While every emergency situation poses unique problems based on external factors, such as time of day and the severity of the disruption, we have been advised by our Electronic Medical Records system that its objective is to restore its own operations and be able provide access to client records in the shortest time possible.
5. Varying Disruptions – Significant business disruptions can vary in their scope, such as only our firm's office, the city where we are located or the whole region. Within each of these areas, the severity of the disruption can also vary from minimal to severe. In the event of a significant business disruption, we have plans to place to move to a back-up location or remote locations as necessary. In either situation, we plan to continue in business, transfer operations by working remotely, and notify you through our website **www.ACRHealthGA.com** or our customer emergency number, **404-508-0078** or alternative number **678-499-8695** how to contact us. If the significant business disruption is so severe that it prevents us from remaining in business, the **Georgia Crisis & Access Line (GCAL) at 1-800-715-4225, available 24/7** will provide individuals/families assistance in receiving services.
6. For more information – If you have questions about our business continuity planning, you can contact us at **404-508-0078 or ACR_Admin@ACRHealthGA.com**

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Policy 10.01 - Contract Employee Policy

I. POLICY:

A. It is the policy of Assertive Community Recovery, LLC (ACR) to employ personnel on a contractual basis to support the mission of our organization.

B. In order to clearly distinguish the types of relationships ACR has with personnel who directly and indirectly support the mission of ACR, the following categories of employment relationships are noted:

1. Regular, or Statutory, Employee:

a. A Regular Employee is defined as an individual who has an employment relationship with ACR in which Federal Income, Social Security, and Medicare taxes are withheld from wages by ACR. In addition state taxes will be withheld, and ACR may be responsible for payment of unemployment insurance taxes. If benefits such as health insurance, retirement account options, medical/child care spending accounts, and vacation, sick, and/or maternity leave are provided, a Regular Employee would be eligible to participate in such benefits.

b. A Regular Employee is required to complete a W-2 form upon hire, with ACR completing all related legal processes, including annual statements of earnings and withholding, as required by the IRS for annual income tax filing.

c. Regular Employees are employees who ACR has the right to control the means and methods of accomplishing the intended results.

2. Contract, or Common Law, Employee:

a. A Contract Employee is defined as an individual who has an employment relationship with ACR in which there is an explicit agreement/understanding, upon hire, that Federal Income, Social Security, and Medicare taxes will not be withheld by ACR. In addition, there is an explicit understanding that there is no obligation on the part of ACR to withhold state taxes, pay unemployment taxes, or provide other benefits such as health insurance, retirement account options, health/child care spending accounts, and paid vacation, sick, and/or maternity leave.

b. A Contract Employee is required to complete a W-9 form upon hire, and ACR is required to complete all associated processes, including providing the

employee with an annual statement of gross earnings (1099 form), as required by the IRS for annual income tax filing.

c. A Contract Employee is an employee who ACR has the right to control the means and methods of accomplishing the intended results.

d. A Contract Employee is covered (as are Regular Employees) by the following legal requirements in all states and territories:

(1) The Disability Discrimination Act
(2) The Race Discrimination Act
(3) The Sex Discrimination and Sexual Harassment Act
(4) The Human Rights and Equal Opportunity Act
(5) The Workplace Relations Act
(6) All Federal and State Privacy legislation
(7) All Federal and State Occupational Health and Safety Acts

3. Independent Contractor:

a. An Independent Contractor is defined as an individual, or individuals within an organization, who are involved in an independent trade, business, or profession in which they offer their services to the public.

b. An Independent Contractor is not required to complete earnings or withholding forms upon engagement with ACR. Compensation is for services provided, and results from the submission of a billing invoice by the Independent Contractor.

c. An Independent Contractor is not considered an employee of ACR, as ACR does not have the right to control the means and methods of accomplishing the intended results, only the right to assess whether intended results were accomplished.

II. PROCEDURES FOR CONTRACT EMPLOYEES:

A. All Contract Employees:

1. Orientation:

a. Contract Employees will participate in ACR's new employee orientation and will complete all required orientation forms and processes, with the following exceptions:

(1) Review of materials and the completion of forms related to the withholding of wages.

(2) Review of employee benefits provided to Regular Employees, along with completion of associated forms.

b. Contract employees will complete a W-9 form during new employee orientation that will result in an annual 1099 Miscellaneous Income Statement provided to the employee by January 31 documenting any wages paid the prior year.

2. Initial and Ongoing Training

a. All Contract Employees will complete required initial and ongoing training in the areas of rights of the persons served, person and family center services, prevention of workplace violence, confidentiality requirements, cultural competency, and expectations regarding professional conduct.

b. All Contract Employees will receive competency-based training upon hire and annually in required health and safety training areas.

3. Adherence to Organizational Policy and Procedure

a. All Contract Employees will adhere to all organizational policy and procedures to include, but not limited to, the areas of organizational legal requirements, corporate compliance, ethical and conduct standards, health and safety practices, human resources, rights of persons served, confidentiality, accessibility, information management, and performance improvement.

4. Contract/Performance Evaluation

a. All contract employees will sign an employment contract with ACR, upon hire. The employment contract will include the following:

(1) The overall role and scope of the work to be performed.

(2) Job functions and related levels of competency expected to be achieved in the performance of duties.

(3) The procedures and methods by which expectations of performance outlined in the contract will be assessed annually.

(4) A statement of agreement that the employee will adhere to all applicable organizational policies and procedures.

(5) Rate of pay, expected hours or days worked, place of work, and supervisory relationships.

(6) Conditions under which the contract can be terminated by each party.

(7) Signatures of parties and date of agreement.

(8) Other areas of obligation, as determined by ACR.

b. All Contract Employees will participate in a review of the performance requirements of their contract on an annual basis, consistent with their date of hire. The review will include the following:

(1) Meeting with the designated supervisor, a representative of human resources, or ACR's owner/CEO.

(2) The completion of a contract/performance review form that will include the job functions and related levels of competency noted on the contract, with documentation of the level that work requirements were achieved.

(3) Discussion, negotiation, and/or decision-making regarding changes in the contract.

(4) Renewal of current contract or agreement to a new and/or revised contract for the next year.

5. <u>Personnel Records</u>

a. All Contract Employees personnel files will include the following:

(1) An employment application or resume

(2) Verification of credentials, when applicable

(3) Evidence of orientation

(4) Employment Contract

(5) Contract performance evaluation reports

(6) Criminal background checks, when applicable

(7) Any other information required by law

6. Input

a. All Contract Employees will participate in employee feedback surveys, and any other methods of obtaining employee feedback utilized by ACR.

b. Information gathering related to performance improvement activities will include the input of Contract Employees for use in the retention of Contract Employees and improvement in operations and service provision.

B. Direct Service Contract Employees:

1. Verification of Credentials

a. ACR's policy and procedures on Verification of Credentials will apply to all Contract Employees involved in direct service provision.

2. Determination of Competency and Competency Based Training

a. Consistent with ACR's policy and procedures for the determination of competencies and competency-based training for personnel engaged in direct service provision, ACR will ensure the following areas of competencies are applied to direct service Contract Employees:

(1) Areas that reflect the specific needs of the person served.

(2) Clinical skills that are appropriate to the position

(3) Individual plan development

(4) Interviewing skills

(5) Program-related research-based treatment approaches.

3. Ongoing Supervision

a. ACR's policies and procedures regarding ongoing supervision of persons who provide direct services will apply to Contract Employees, with the following exclusions:

(1) Supervisory performance evaluations will follow the contract review process noted in the Contract Employee Policy.

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Policy 10.02 - Renewal of Independent Contractor Agreement

I. POLICY:

A. It is the policy of ACR to ensure that independent contractors are screened and fully capable of providing services in accordance with applicable guidelines and directives.

II. PROCEDURES:

A. All contract agreements will be renewed within a 12-month period. Prior to the renewal of the contract, all independent contractors must show evidence of the following:

1) Copy of Insurance Liability
2) Copy of current licenses, if applicable
3) Background investigation results
4) Copy of Social Security Card/EIN#

B. The independent contractor's files will be updated with the background investigation results and updated licensure, if applicable.

C. The independent contractor will attend a brief orientation within seven (7) days of signed contract, to ensure that all new policies and procedures have been explained and presented in accordance with state and federal regulations.

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Policy 10.03 - Hiring of Staff

I. POLICY:

In an effort to offer quality services to consumers, ACR hires an array of staff (licensed and non-licensed) to assist in specialty services to meet the needs of our consumers. All staff hired into positions that require licensure, credential or certification will be licensed or credentialed by the appropriate Georgia agency with the authority to do so. License, certifications or credentials from any jurisdiction other than Georgia will be accepted. Evidence of professional competence and licensure are documented and maintained in staff's personnel file. Student, trainees and interns can only provide clinical duties when they are appropriately supervised by a licensed professional in their field.

ACR always strives to ensure a diverse culture of staff to meet the needs of the individuals and families we serve.

ACR hires staff on the basis of information provided on the applicant's resume, application and reference list. The information is verifiable through both verbal and written background checks. The company verifies background checks for staff in accordance with state and local laws.

All staff will be expected to follow all Company policies and procedures. A Personnel Policies Procedures Manual will be reviewed during new hire orientation.

Hiring procedure

1. ACR will post open positions with various agencies, via Internet, and public periodicals to search for qualified candidates to fulfill current contract assignments.
2. Once the Executive Director and/or Clinical Director have reviewed resumes, candidates will be selected for an interview.
3. Candidates will meet with the Executive Director and the Clinical Director to determine if their skills and background meet the requirements of the position.
4. Once a final candidate has been selected for the position, the candidate will be required to provide credentials that must verified and undergo a background checks in accordance with ACR Policy 10.13 - Verification of Credentials and Background Checks.
5. The Human Resource Director or Clinical Director will also conduct a reference check from a provided reference list.

6. Once the results of the background check have been verified, the Chief Executive Officer will make a final decision as to whether or not to hire the staff for the position.
7. An application will be completed and approved by both parties prior to the start of the assignment. The contract will consist of the contract assignment, pay rate, hours of expected workweek, length of contract, and termination of contract, if necessary.

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Policy 10.04 - Release of Personnel Employment Information

PURPOSE:

To establish guidelines for the retention and release of employment information regarding program staff members.

POLICY:

ACR shall maintain staff member's personnel records as a central depository of employment information and such information will be maintained in a confidential manner.

PROCEDURES:

Release of Confidential Employment Related Information:

A. Employment (reference requests):

   1. Only provided to authorize individuals of the requesting organization.

   2. Only provided regarding former staff members who provide written authorizations to release such information.

   3. Current staff members must provide written authorization prior to release.

   4. Requests with proper authorization will be responded to by phone and/or in writing.

B. Credit or financial information, releases, or verifications:

   1. Information will be released at the request of and for the convenience of staff members.

   2. The financial institution should provide forms for the specific information requested.

3. Employment verification for credit purposes will be permitted. Information and employment data will be verified if previously provided to the credit organization by the staff member. No additional information will be released;

   verification will state that the information is correct or incorrect but if incorrect, the correct information will be released.

C. Request for information from organizations with legal authority will be honored:

1. Georgia Department of Labor

2. Bureau of Workers' Compensation

3. Federal government agencies

4. Courts

D. Requests by physicians or public safety personnel or others on an emergency basis.

1. The authenticity of the caller will be verified.

2. The program staff to recommend direct contact between parties by contacting the staff member.

3. If serious emergencies are involved, only the information required to meet the need will be released.

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Policy 10.05 - Anti-Harassment Policy/Complaint Procedure

POLICY:

The office strives to create and maintain a work environment in which people are treated with dignity, decency and respect. The environment of the office should be characterized by mutual trust and the absence of intimidation, oppression and exploitation. Staff/independent contractors should be able to work and learn in a safe, yet stimulating atmosphere. The accomplishment of this goal is essential to the mission of the office. For that reason, the office will not tolerate unlawful discrimination or harassment of any kind. Through enforcement of this policy and by education of staff/independent contractors, the office will seek to prevent, correct, and discipline behavior that violates this Policy.

All staff and independent contractors, regardless of their position, are covered by and are expected to comply with this policy, and to take appropriate measures to ensure that prohibited conduct does not occur. Appropriate disciplinary action will be taken against any staff/contractor that violates this policy. Based upon the seriousness of the offense, disciplinary action may include verbal or written reprimand, suspension, or termination of employment/independent contract.

Conduct Prohibited Under This Policy

1. Discrimination:

a) It is a violation of this Policy to discriminate in the provision of employment opportunities, to create discriminatory work conditions, or to use discriminatory evaluative standards in employment if the basis of that discriminatory treatment is, in whole or in part, the person's race, color, national origin, age, religion, disability status, gender, sexual orientation, or marital status.

b) Discrimination of this kind may also be strictly prohibited by a variety of federal, state and local laws, including Title VII of the Civil Rights Act 1964; the Age Discrimination Act of 1975; and the Americans With Disabilities Act of 1990. This Policy is intended to comply with the prohibitions stated in these anti-discrimination laws.

c) Discrimination in violation of this Policy will be subject to severe sanctions up to and including termination.

2. Harassment:

Harassment, including sexual harassment, is prohibited by federal and state laws. This Policy prohibits harassment of any kind, and the office will take appropriate action swiftly to address any violations of this policy. The definition of harassment is: verbal or physical conduct designed to threaten, intimidate or coerce. Also, verbal taunting (including racial and ethnic slurs) which, in the staff's/independent contractor's opinion, impairs his or her ability to perform his or her job.

Examples of harassment are:

(1) Verbal: Comments which are not flattering regarding a person's nationality, origin, race, color, religion, gender, sexual orientation, age, body disability, or appearance. Epithets, slurs, negative stereotyping.

(2) Non-verbal: Distribution, display or discussion of any written or graphic material that ridicules, disparages insults, belittles, or shows hostility or aversion toward an individual, or group because of national origin, race color, religion, age, gender, sexual orientation, pregnancy, and appearance disability, marital or other protected status.

3. Sexual Harassment:

Sexual harassment in any form is prohibited under this policy. Sexual harassment is a form of discrimination and is unlawful under Title VII of the Civil Rights Act of 1964. According to the Equal Employment Opportunity Commission (EEOC), sexual harassment is defined as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when submission to or rejection of such conduct is used as the basis for employment decisions or such conduct has the purpose or effect of creating an intimidating, hostile, or offensive working environment."

Sexual harassment includes unsolicited and unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature, when such conduct:

a) Is made explicitly or implicitly a term or condition of employment or contract, or

b) Is used as a basis for an employment decision, or

c) Unreasonably interferes with a staff's or independent contractor's work performance or creates an intimidating, hostile, or otherwise offensive environment.

Sexual harassment does not refer to behavior or occasional compliments of a socially acceptable nature. It refers to behavior that is unwelcomed, that is personally offensive, and that lowers morale and therefore interferes with work effectiveness. Sexual harassment may take different forms.

Examples of conduct that may constitute sexual harassment are:

(1) Verbal: Sexual innuendoes, suggestive comments, and jokes of a sexual nature, sexual propositions, lewd remarks, and threats. Requests for any type of sexual favor (this includes repeated, unwelcome requests for dates). Verbal abuse or "kidding" which is oriented towards a prohibitive form of harassment, including that which is sex oriented and considered unwelcome.

(2) Non-verbal: The distribution, display, or discussion of any written or graphic material, including calendars, posters, and cartoons that are sexually suggestive, or shows hostility toward an individual or group because of sex; suggestive or insulting sounds; leering; staring; whistling; obscene gestures; content in letters and notes, facsimiles, e-mail, that is sexual in nature.

(3) Physical: Unwelcome, unwanted physical contact, including but not limited to, touching, tickling, pinching, patting, brushing up against, hugging, cornering, kissing, fondling; forced sexual intercourse or assault.

Normal, courteous, mutually respectful, pleasant, non-coercive interactions between staff/independent contractors, including men and women that are acceptable to and welcomed by both parties, are not considered to be harassment including sexual harassment.

PROCEDURES:

What you should do if you are a victim of sexual harassment:

a. If you are the recipient of any unwelcome gesture or remark of a sexual nature, do not remain silent.

b. Make it clear to the harasser that you find such conduct offensive and unwelcome. State clearly that you want the offensive conduct to stop at once.

c. Review the complaint procedure set forth in this document. If you decide to file a complaint, please contact the Program fill out the complaint form

d. You may wish to keep a written log of all incidents of harassment, noting the date and time, place and persons involved, and any witnesses to the event.

4. Consensual Sexual Relationships:

a. ACR strongly discourages romantic or sexual relationships between management and staff/independent contractors.

Retaliation

1) No hardship, no loss or benefit, and no penalty may be imposed on a staff/independent contractor as punishment for:

a) Filing or responding to a bona fide complaint of discrimination or harassment;

b) Appearing as a witness in the investigation of a complaint; or

c) Serving as an investigator.

2) Retaliation or attempted retaliation is a violation of this Policy and anyone who does so will be subject to severe sanctions up to and including termination.

The Complaint Process

Any person electing to utilize this complaint resolution procedure will be treated courteously, the problem handled swiftly and as confidentially as feasible in light of the need to take appropriate corrective action, and the registering of a complaint will in no way be used against the staff/independent contractor, nor will it have an adverse impact on the individual's employment status. While reporting such incidents would be a difficult personal experience, allowing harassment activities to continue will most certainly lead to less desirable outcomes. For that reason, staff/independent contractors are strongly urged to utilize this procedure. However, filing groundless and malicious complaints is an abuse of this policy and is prohibited.

Confidentiality

1. All information during a harassment investigation will be kept confidential. There may be time when information needs to be shared with Legal Counsel to conduct next steps in the investigation.

Complaint Procedure

The following complaint procedure will be followed in order to address a complaint regarding, harassment, discrimination, or retaliation.

1. A person who feels harassed, discriminated or retaliated against may initiate the complaint process by filing a written and signed complaint with the Director of Human Resources or if the complaint involves the HR Director, the complaint will presented to CEO. No formal action will be taken against any person under this Policy unless a written and signed complaint is on file containing sufficient details to allow the HR Director or Chief Executive Officer to determine if the policy may have been violated.

2. Within five (5) working days of receiving the complaint, the HR Director or Chief Executive Officer will:

   a) Provide a copy of the complaint to the person(s) charged (hereafter referred to as "respondent(s);" and

   b) Initiate the investigation to determine whether there is a reasonable basis for believing that the alleged violation of this Policy occurred.

3. During the investigation, the HR Director or Chief Executive Officer will interview the complainant, the respondent, and any witnesses, to determine whether the conduct occurred.

4. Within fifteen (15) business days of the complaint being filed Chief Executive Officer will conclude the investigation and submit a report of his or her findings to Legal Counsel, complainant, and respondent.

5. If it is determined that harassment or discrimination in violation of this company's policy has occurred, the Chief Executive Officer will recommend that appropriate disciplinary action to be taken by the company.

6. If the investigation is inconclusive or it is determined that there has been no harassment or discrimination in violation of this Policy, but some potentially problematic conduct is revealed, preventative action may be taken.

7. Within five (5) days after the investigation is concluded, the Chief Executive Officer will meet with the complainant and the respondent separately, in order to notify them in person of the findings of the investigation and to inform them of the action being recommended by the Chief Executive Officer.

8. The complainant and the respondent may submit statements to the Chief Executive Officer challenging the factual basis of the findings. Any such statement must be submitted no later than five (5) working days after the meeting with the Chief Executive Officer in which the findings of the investigation is discussed.

9. Within ten (10) days from the date the Chief Executive Officer meets with the complainant and respondent, the company will review the investigative report and any statements submitted by the complainant or respondent, discuss results of the investigation with the Chief Executive Officer and other management staff as may be appropriate, and decide what action, if any, will be taken. The company's decision will be in writing and will include finding of fact.

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Policy 10.06 - Staff Development

I. POLICY:

The ability of ACR to carry out its mandated responsibilities is dependent to a large degree on the knowledge, skills, and capabilities of staff in all functional areas. It is essential that staff is recruited and maintained who are capable of meeting the needs of the system at the highest possible level. While existing or potential staff may possess certain skills and a given knowledge base, it is critical that they are properly introduced to, knowledgeable of, and capable of performing support activities of this system.

The purpose of a staff development program is not only to enhance the capability of system to perform its functions, but also to supplement the personal development of staff. We must respond to the individual's needs for growth and development and expansion of his/her frame of reference. It is the policy of this agency:

A. To establish supplementary policies to govern career development and education and training.

B. To develop and implement procedures that will maximize effective development and utilization of staff.

C. To facilitate cooperation and coordination of system wide staff development activities as appropriate and needed.

II. Incentive Awards:

A. ACR will develop and implement an employee incentive programs as a way of compensating and motivating employee performance with pay and benefits. Most research proves that it's not money alone that inspires employees to do their best.

B. Examples of incentives that ACR Health Services may use to increase employee performance include:

1) Give top-rated employees first choice on new jobs
2) Invest in learning & development programs
3) Bonuses and rewards tied to goal achievement and performance
4) Implement key performance indicators
5) Employee of the month
6) Track goals and performance in team meetings
7) Establish team awards for goal performance

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Policy 10.07 - Orientation for Staff

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to establish guidelines for the development of orientation for staff and to implement ACR's policies and procedures for each new staff beginning on the first day of employment..

II. PROCEDURES:

A. All staff will be required to attend orientation as an employment requirement prior to assignment to direct services. Services will be coordinated by the Human Resource Manager with various personnel giving the presentation

B. The following items outlined below will be reviewed during orientation with staff:

1. Overview of Assertive Community Recovery, (ACR)
    a. Organizational Flow Chart
    b. History of Agency
    c. Mission, Values and Goals of agency
    d. Expectations
2. Overview of ACR's Programs

    Programs and Descriptions (CORE, ACT and Peer Support)
3. Human Resources
    a. Duties and responsibilities in brief
    b. Pay Days and Holidays
    c. Policies:
        i. Confidentiality
        ii. No Smoking
        iii. Drug/Alcohol
    d. Email Addresses
    e. Staff Directory
4. Explanation and issuance of policies and procedures
    a. Code of Conduct
    b. Medicaid Fraud

c. Documentation
d. Safety in the Community
e. Transportation Safety
f. Critical Incident Reporting
g. Alleged or Suspected Abuse/Neglect
h. Crisis Intervention
i. Emergency Intervention, Seclusion, and Restraints
j. Universal Precaution
k. Documentation
l. Confidentiality
m. Rights of Persons Served
n. Anti-Harassment and Compliant Policy and Procedure
o. Employee Grievance
p. Program participant Grievance
q. Emergency Intervention, Seclusion, and Restraints

5. Hours of work/reporting procedures
6. Wages and payday
7. Completion of all personnel enrollment forms
8. Tour of Facility
9. Emergency Codes and Procedures
10. Absenteeism and tardiness
11. Essential Learning Overview
12. Sharenote Overview
13. Documentation Training and Policy
14. CPR and First Aide

C. Training for Staff who will have direct contact with consumers will provided in accordance with ACR Policy 09:12 Staff during this orientation period and before they will be assigned duties with direct service responsibilities.

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Policy 10.08 - Performance Evaluation

I. POLICY:

A. It is the policy of Assertive Community Recovery, LLC (ACR) to utilize an employee performance evaluation process that supports improvement of employee performance through a comprehensive competency-based assessment of responsibilities and skills required to support the mission of the organization.

B. The employee performance evaluation process is designed to support employees in skill development, require accountability from both the organization's leadership and employees, and serve as a database for organizational performance improvement.

II. PROCEDURES:

A. Timelines for Employee Performance Evaluations:

1. 90-Days After Date of Employment:

a. Each new employee will receive a job description during new employee orientation, which will outline the job duties and responsibilities of the position.

b. The job description will be signed and dated by the employee, indicating their understanding of their job duties and responsibilities, with a copy given to the employee and the original placed in the employee's personnel file.

c. The performance evaluation form for the employee's specific job position will be reviewed with new employees to acclimate them to the individual performance evaluation process.

d. Within 14 days prior to each new employee's 90-day probationary period, the designated supervisor of the

employee will conduct a performance evaluation using the ACR's standardized evaluation form and format.

e. The performance evaluation results will be utilized as one of several measures to determine if employment will be continued.

2. **Annual Performance Evaluations**:

a. All employees will participate in an annual performance evaluation process on an annual basis.

b. The performance evaluation will occur within 14 days of their employment anniversary date.

c. Supervisors are responsible for conducting employee performance evaluations through completing the standardized evaluation format, reviewing the results with the supervisee, and working with the supervisee to establish goals and measurable objectives for the next year to support improved performance of the employee.

B. Components of the Performance Evaluation Process:

1. **Review of Goals From the Previous Evaluation:** Goals and objectives that were established on the last performance evaluation are reviewed to determine the status with regard to being met or unmet. Goals and/or objectives that are determined to be unmet can be carried over to the next evaluation period or eliminated if they are no longer relevant.

2. **Review of Specific Job Functions and Competency Requirements:** The employee's supervisor will complete the ratings for each of the noted job functions on the form, which are consistent with the position's job description. The ratings will be discussed with the employee to assist in understanding specific job behaviors associated with the level of the rating.

3. **Review of Organizational Work Expectations:** The employee's supervisor will complete the ratings for each of the noted work expectations on the form. The work expectations are general in nature and apply to all employees. The ratings will be discussed with the employee to assist in understanding specific job behaviors associated with the level of rating.

4. **Development of Goals and Objectives Established for the Next Evaluation Period**: Based on the results of the level of ratings and discussion between the supervisor and employee, goals and specific measurable objectives will be determined and noted on the evaluation form. These will be used to assist employees with increased education and skill development over the next year, and will be a major component of the ongoing day-to-day supervision process.

5. **Employee Disagreement With the Evaluation Results:** Should an employee disagree with their supervisor's evaluation of their performance, they will be directed to the employee grievance policy in the employee handbook to guide their appeal of the results.

C. Administrative Flow and Storage of Performance Evaluations

1. **Determination of Required Review Dates:** The HR Coordinator is responsible for informing each supervisor of the due date of the required 90-day or annual evaluation, through a tracking system of all employee start/evaluation dates. This information is provided to the supervisor at least 30 days in advance of the 14-day window the supervisor is given to complete the evaluation.

2. **Distribution of Past and Current Evaluation Forms:** The HR Coordinator will provide each supervisor with the employee's past evaluation, and a form for the completion of the current evaluation. The past evaluation will be used to assist in the review of the goals and objectives for the past year.

3. **Evaluation Completion and Signatures:** Each employee and their supervisor will sign the evaluation form at the end of meeting in which it is completed. The form (along with last year's form) will be returned to the HR Coordinator, who will review the current evaluation form for thoroughness and sign it. The form will then be forwarded, for review and signature, to the Executive Director. Following the review and signing by all participants, the HR Coordinator will file the form (along with last year's form) in the employee's personnel file.

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Policy 10.09 - Employee Grievance Policy

I. POLICY:

A. It is the policy of ACR to resolve workplace issues and problems by providing employees with an internal grievance procedure that ensures any problems or complaints are considered quickly, fairly, and without fear of reprisal.

B. The Quality and Compliance Officer is responsible for ensuring that the procedures in this policy are followed and met.

C. A grievance may be filed by an employee for any of the following reasons:

1. Any disciplinary action taken by a supervisor. These include written warnings, disciplinary suspension without pay, demotion or dismissal.

2. Any instance of illegal discrimination perceived by an employee.
Note: *All employees have the legal right to file a discrimination complaint with state and federal regulatory agencies and are not restricted to the internal grievance procedure, nor required to file an internal grievance.*

3. Any instance of unlawful workplace harassment perceived by an employee.
Note: *All employees have the legal right to file a discrimination complaint with state and federal regulatory agencies and are not restricted to the internal grievance procedure, nor required to file an internal grievance.*

II. PROCEDURES:

A. INFORMAL RESOLUTION:

1. A positive relationship between employees and supervisors is based on mutual trust, respect, and open communication. If employees have a problem in the workplace related to employment, they are encouraged to first discuss the issue or concern with their immediate supervisor. In most cases, these discussions can resolve any misunderstandings or conflicts.

2. If informal discussion is not effective in resolving concerns, employees are encouraged to utilize the formal grievance resolution procedures.

B. FORMAL RESOLUTION

1. Steps of the Grievance Review:

1) Step 1: To initiate a grievance, an employee must file a written Notice of Grievance (ACR Form 10.09a) within 14 days of the contested action or incident with the HR Representative. The notice must state specifically what is being grieved, what relief is being sought, and must include a description of the efforts the employee took to settle the complaint informally.

2) Step 2: The HR Representative will initiate an investigation of the complaint by taking the following actions:

i. Sending a copy of the Notice of Grievance to the supervisor involved, if applicable.

ii. Sending a copy to the CEO

iii. Conducting interviews with persons involved, if appropriate.

iv. Rendering a final decision, in writing.

3) Step 3: The HR Representative will provide a written response to the grievant within 7 days of receiving the Notice of Grievance. The written response will contain one of the two following outcomes:

i. Grievance Unfounded: This outcome may include a brief justification regarding the decision.

ii. Grievance Founded: This outcome may include actions that will be taken to resolve the problem and/or information related to meeting with specific management employees to assist in remedying the situation.

4) Step 4: Should the written response note the grievance as unfounded, employees may appeal the decision to the CEO. The appeal must be in writing within four days of the employee receiving the "unfounded" response. A copy of the prior Notice of Grievance and written response must be attached.

5) Step 5: The CEO will provide a written response to the grievant within 7 days of receiving the written appeal of the initial grievance response. The written response will contain one of the two following outcomes:

    i. Grievance Unfounded: This outcome may include a brief justification regarding decision.

    ii. Grievance Founded: This outcome may include actions that will be taken to resolve the problem and/or information related to meeting with specific management employees to assist in remedying the situation.

C. GRIEVANCE REVIEW BOARD

1. Should an employee wish to continue to the grievance process following an "unfounded" result of an appeal of the initial outcome, they may initiate a review by the Leadership Team by indicating in writing to the HR Representative they wish to participate in the review process with the Leadership Team.

2. Procedural information related to the proceedings, will be provided to all parties prior to the proceedings.

3. The HR Representative will serve in a non-voting advisory capacity to the review board to assist with procedural structure.

4. The Leadership Team will operate according to the following procedural guidelines:

    a. Both of the opposing parties (employee and supervisor) will be present during presentation of the case to the Leadership Team. Neither party may interrupt the case being presented by the other side. The board will have the right to limit lengthy discussion deemed to not focus directly on the grievance.

    b. Each party will have the right to provide evidence or documentation relevant to the case. Both parties will be required to submit any documentary material or witness lists three days prior to the review.

    c. Documentation not submitted and/or witnesses not listed will not be entered into the process once the review board convenes.

d. Each party may receive a copy of the other parties' documentary material and witness list on the work day preceding the review from the HR Representative.

e. Each party has the right to call witnesses; however, witnesses will only be present during their testimony. It will be the responsibility of the grievant and the supervisor to notify their witnesses of the time, place and date of review.

f. The grievant and the supervisor may recommend the order of testimony and the appearance of witnesses for their respective sides.

g. Documentary material and/or testimony may be denied, by the review board, in the hearing if deemed to be unnecessarily repetitive or irrelevant.

h. The Leadership Team will reach its findings and present its recommendations to the CEO within 14 calendar days of the review.

i. The CEO may accept the Leadership Team's recommendation in whole or in part.

j. The grievant will be informed of the final decision by the CEO in writing, within 7 days of receiving the recommendations from the Leadership Team.

5. Should the appeal to the Grievance Review Board result in a dissatisfactory outcome for the employee they are encouraged to seek assistance from external entities, on their own time and at their personal expense.

Attached: Notice of Grievance (ACR Form 10.09a)

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Policy 10.10 - Competency Based Training Plan

Assertive Community Recovery understands that all of its staff members are expected to perform at an optimal level at all times. The organization recognizes that the unit of progression that it must operate by is one in which a mastery of specific knowledge and skills is reviewed and learned through the area of participation.

The two key terms used in competency-based training are:

- Skill – A task or group of tasks performed to a specific level of competency or proficiency which often use motor functions and typically require the manipulation of instruments and/or equipment. Some skills, however, such as counseling, are knowledge and attitude based.

- Competency – A skill performed to a specific standard under specific conditions.

A competent clinician is one who is able to perform a clinical skill to a satisfactory standard. Competency-based training is based upon the participant's ability to demonstrate attainment or mastery of clinical skills performed under certain conditions to specific standards. These skills then become competencies.

ACR aspires to the following five essential elements in it's Competency Based Training System:

- Competencies to be achieved are carefully identified, verified and made public in advance.

- Criteria to be used in assessing achievement and the conditions under which achievement will be assessed are explicitly stated and made public in advance.

- The instructional program provides for the individual development and evaluation of each of the competencies specified.

- Assessment of competency takes the participant's knowledge and attitudes into account but requires actual performance of the competency as the primary source of evidence.

- Participants progress through the instructional program at their own rate by demonstrating the attainment of the specified competencies.

Characteristics of Competency-Based Training Programs

- Competencies are carefully selected.

- Supporting theory is integrated with skill practice. Essential knowledge is learned to support the performance of skills.

- Detailed training materials are keyed to the competencies to be achieved and are designed to support the acquisition of knowledge and skills.

- Methods of instruction involve mastery learning, the premise that all participants can master the required knowledge or skill, provided sufficient time and appropriate training methods are used.

- Participants' knowledge and skills are assessed as they enter the program and those with satisfactory knowledge and skills may bypass training or competencies already attained.

- Learning is self-paced.

- Satisfactory completion of training is based on achievement of all specified competencies.

The primary sources of competency based training that will be utilized by ACR are Essential Learning and Accreditation Now.

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Policy 10.11 - Attendance and Punctuality

PURPOSE:

To maintain a safe and productive work environment, ACR expects staff to be reliable and to be punctual in reporting for scheduled work duties. To promote satisfactory attendance and promptness: to control absenteeism, thus helping maintain effective staffing levels and operational productivity.

POLICY:

ACR considers unnecessary and excessive absenteeism or tardiness a serious matter and one that interrupts departmental routines, the workloads of other staff members and the company's ability to provide effective services.

PROCESS

Each staff member is responsible for tracking his or her time. Supervisors and Managers are to monitor staff member's time cards on a weekly basis. Any discrepancies in attendance or punctuality should be addressed by the staff member's supervisor.

- The employer will keep accurate and up-to-date records of all staff member's absences to include the following:
  a. Scheduled and unscheduled absences.
  b. Absences for which staff member is, and is not entitled to pay.
  c. Tardiness and early leave.

- The department manager is responsible for maintaining adequate and up-to-date records of absences and tardiness.
- Staff members must give satisfactory explanations for their absences to the supervisor-designated representative, following departmental requirements. When a staff member is ill, he or she must notify their immediate supervisor as soon as possible, in accordance with the rules established within the department.

- If a staff member is not able to meet with the client's on their schedule/caseload, the Team Leader will assign someone to

continue clinical coverage of that particular client and all clients on the schedule/caseload of the staff member that is absent.

- Unreported absence is considered a serious infraction of the company's rule and standards of conduct. Staff members are responsible for providing prompt notice to appropriate supervisor if they cannot report for work at the regularly scheduled time.

- A staff member is considered to have resigned without notice and their employment will be terminated if they do not report to work for two consecutively scheduled workdays and fail to notify the supervisor.

- Any staff member unable to work due to illness for more than three consecutive days should contact the immediate supervisor. The supervisor is to contact Human Resources to ensure continuity of benefits; review eligibility for extended sick leave time, is appropriate, and discusses any requirements for a physicians verification of the illness and expectations regarding the staff member's return to work.

- If the supervisor cannot contact a staff member, the Clinical Director will be immediately notified so that contact can be made with the staff member regarding their status.

- Staff members may be subject to disciplinary action for unreported absences or tardiness and for excessive absenteeism or tardiness.

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Policy 10.12 - Treatment Team

POLICY:

It is the policy of ACR to provide the highest standard of care to facilitate and enhance the ability of individuals to maintain qualitative lifelong wellness. In order to effectively provide this service, ACR will only employ qualified providers who have expertise in the most up to date and optimal services to support the recovery of individuals. These personnel may include: Counselors, Social Workers, Therapists, Physicians/Psychiatrists/ Psychologists, Nurses, referral agents, administrative and office personnel who come from many multi-faceted diverse backgrounds beliefs and cultures.

It is ACR's philosophy that through effective communication and recovery management, the individual can best benefit from being provided services from multi-disciplinary team that meets regularly to review the individual's recovery progress and develop interventions that are integrate and respects each specialized knowledge and expertise of each team member. Therefore, the Treatment Team assumes authority in clinical decisions over any individual counselor's decision. ACR has thus established the following procedure.

PROCEDURES:

The CEO and Clinical Director are responsible for facilitating, documenting and ensuring that weekly staff meetings are held to clinically manage each individual's care and assist in the design and implementation of individualized treatment planning, oversee progress, discuss transition planning, and identify/address further individual related needs and services.

The Treatment Team shall consist of all ACR counselors, both staff and contract employees, and an educational specialist for adolescent clients when indicated. If ACR has an adolescent client in treatment that is not in school, the educational specialist will be contacted for team meetings; otherwise ACR staff will attempt to use existing teachers and school counselors to coordinate any services and give/receive input.

Further, to promote open and effective communication throughout the ACR spectrum of services, any agency wide changes and/or needs will be separately addressed in this forum.

All documentation of meetings shall be kept in the Treatment Team Notebook located in the Clinical Director's office. Notes on individual clients shall be documented accordingly in their progress notes section.

All staff members shall be informed of the Treatment Team meeting times upon initial hire, and thereafter if changes are made.

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Policy 10.13 - Verification of Credentials and Background Checks

I. POLICY:

A. It is the policy of Assertive Community Recovery, LLC (ACR) to verify the credentials of personnel hired and employed by the organization with the primary source of the credentials. In addition, the backgrounds of personnel will also be verified. The verification process will be done in a manner that ensures the organization's requirements for employment are met, and the integrity of our services and the persons served are not compromised.

B. The Human Resource Director is responsible for ensuring that the procedures in this policy are followed and met.

II. PROCEDURES:

A. VERFICATION OF CREDIENTIALS:

1. All credentials required of potential employees to hold specific positions in the organization will be verified with the primary source prior to employment (with exceptions noted in d. below). Requirements of credentials will be determined through job descriptions, which identify the educational, training, credentialing, and/or licensure requirements of each position. Initial verification will occur in the areas noted below as follows:

1) Professional Licensure: (1) The potential employee will provide a copy of the required license to the human resource department as part of the pre-employment process. (2) Human resource personnel will determine the appropriate agency to contact, based on the type of license. (3) The licensure agency will be contacted via web site, phone call, or fax to determine if the license is current and in good standing. (4) Human resource personnel will note the outcome of the action by completing the verification form/checklist and placing it in the employee's personnel folder. Any additional documentation sent for verification will also be placed in the personnel folder. (5) If the potential employee is in good standing, final hiring procedures will be completed. If the potential employee is does not have a current license or is not in good standing with the licensing board, employment will not occur. (6) If employment is offered and accepted, the employee will provide human resources with a copy of professional license within 30 days of each annual renewal.

2) Professional Certification: (1) The potential employee will provide a copy of the required certification to the human resource department as part of the pre-employment process. (2) Human resource personal will determine the appropriate agency to contact, based on the type of certification. (3) The

certification agency will be contacted via web site, phone call, or fax to determine if the certification is current and in good standing. (4) Human resource personnel will note the outcome of the action by completing the verification form/checklist and placing it in the employee's personnel folder. Any additional documentation sent for verification will also be placed in the personnel folder. (5) If the potential employee is in good standing, final hiring procedures will be completed. If the potential employee is does not have the required certification or is not in good standing with the certification board, employment will not occur. (6) If employment is offered and accepted, the employee will provide human resources with a copy of professional certification within 30 days of each annual renewal.

3) Education (higher education degrees): (1) Potential employees will be instructed to have the institution from which the degree was obtained send a notarized or appropriately identified transcript directly to the employer. (2) Human resource personnel will review the transcript to ensure it is a valid document and compare data contained on the document with employment requirements. (3) If the educational materials meet requirements, final hiring procedures will be completed. If they do not, the potential employee will not be hired for the position.

4) Exception to Education Verification Requirements: Due to the lengthy response time of most educational institutions in providing the required information, verification of education prior to active employment can be waived if the ALL of the following conditions are met: (1) A copy of the required degree is provided. (2) The employee's supervisor has been notified that verification has not occurred and this is documented in the personnel file. (3) The verification from the primary source occurs within 90 days of the first official date of employment.

5) Training: If a position requires the completion of a specific training to be eligible for employment, the training will be verified prior to the start of employment in the following manner: (1) The potential employee will provide the human resources department with the original training certificate (2) If the original training certificate is not available, the employee will contact the training organization or educational institution and request that verification of training be sent to the employer (3) The employer will copy the original training certification and place copy in the employee's personnel file, or place verification materials received from outside source in personnel file.

B. BACKGROUND CHECKS

1. Background checks will occur to ensure that the health, safety, and well being of persons served, staff, and other stakeholders involved with services of the organization is not compromised. In addition, background checks will decrease loss exposure for the organization. Background checks will be required in the following areas before an individual can start employment:

a. **Criminal Checks:** A comprehensive national criminal records check (NCIC) will be done on all employees who provide services, supports, care and treatment to persons served. ACR will follow Georgia Department Human Resource (DHR) Policy #504, "Criminal Records Checks and Investigations." Fingerprints shall be obtained by electronic fingerprint submission through Cogent Systems. More information can be obtained from www.cogentid.com.

b. There is a Mandatory disqualification from employment for a minimum of five (5) years from the date of conviction, plea of no lo contendere, or release from incarceration or probation, whichever is later, is required for the following crimes:

1. Murder or felony murder;
2. Attempted murder;
3. Kidnapping;
4. Rape;
5. Armed robbery;
6. Cruelty to children;
7. Sexual offenses;
8. Aggravated assault;
9. Aggravated battery;
10. Arson;
11. Theft by taking, by deception or by conversion; and
12. Forgery in the first degree.

c. Regardless of the date, unless exception is recommended by the Regional Coordinator and approved by the Division Director for DBHDD, ACR is prohibited from hiring into positions providing services, supports, care and treatment any persons convicted of the following:

1. Child, individual or patient abuse;
2. Child, individual or patient neglect;
3. Child, individual or patient mistreatment;

d. The following minimum sanctions are to be imposed on applicants who have been convicted of a criminal drug offense:

(1) Disqualification from employment in any position for a period of two (2) years from the date of conviction for the first offense;

(2) Disqualification from employment in any position for a period of five (5) years from the most recent date of conviction for the second or subsequent offense.

NOTE: For purposes of this disqualification, "conviction" does not include treatment under the Georgia First Offender Act or a plea of nolo contendere.

e. Applicants/employees may also be disqualified from employment, as determined appropriate by hiring officials or designees, if criminal history records indicate any of the following that have direct relevancy to the responsibilities or duties of the position:

(1) Any other conviction or pattern of convictions;

(2) A pattern of recent arrests; or,

(3) A significant recent arrest. (Disqualification to apply until such time as the charge is resolved.)

f. Unsatisfactory background checks may result in disqualification from employment or termination. After completion of the NCIC, DHR will advise ACR in writing of one of the following:

(1) There is no criminal history record;

(2) There is a criminal history record that would prohibit hiring or requires dismissal; or

(3) There is a criminal history record that may be job-related and requires close review.

g. ACR Will take the following actions upon the receipt of written determination from DHR:

(1) The written determination concerning the criminal history information must be maintained and must be filed separately from any type of personnel file.

(2) If the written determination from DHR shows that there is no criminal history, no further action by the hiring unit is necessary.

(3) If the written determination from DHR shows that there is a criminal history that prohibits employment, the ACR will not hire or terminate the employee.

(4) If the written determination from DHR shows that there is a criminal history that may be job-related, the HR Director or designee shall contact the DHR Office of Inspector General (OIG) to discuss. After a close review, the HR Director in consultation with the CEO/Executive Director will make an employment determination.

h. **Temporary Waiver of Employment Start:** Due to the time it takes to process and obtain background information, an employee may be hired in a probationary status if the position is deemed to be “low risk” for loss exposure to the organization. This includes positions with ongoing supervision or administrative positions that do not involve high-risk fiscal activities. Under no circumstances will an employee be hired without a background check if working with persons served in an unsupervised role or working with children and adolescents.

i. **Motor Vehicle Driving History (MVR):** All employees who have or may have responsibility to transport consumers must have a current Georgia Drivers license and provide a copy of a their current Georgia Department of Motor Vehicle Driving History (MVR). A negative MVR may result in disqualification from employment. In some cases individuals with negative information on their

MVR may be hired after they can provide proof of successful completion of an approved defense driving class.

III. Responsibilities

a. ACR will retain as permanent record any and all official copies of academic and professional credentials used in the screening process for newly hired employees as well as those used in the screening for promotion, interagency transfer and permanent reassignments. Such evidence of credentials will be retained in the employee's personnel file. The employee's supervisor is responsible for insuring that affected employees are notified of their responsibility to request such documents (official transcripts, certificates, etc.) from the awarding institution(s). The affected employee is also responsible for the expense associated with this requirement.

b. The Human Resources Office is responsible for Initial Primary Source Verification of credentials (via Internet, and official transcripts must be mailed directly to HR Office from awarding institutions.)

c. The Human Resource Director is responsible for identifying document requirements and subsequently for insuring that any and all personnel records are suspended until the credentialing documents are posted to the personnel file. The HR Director will notify the Clinical Director of such suspensions in excess of 30 consecutive days in order that a resolution can be affected.

d. The HR Director is further responsible for insuring that newly hired employees are adequately notified of this policy during their employment orientation process and, as well, insure that aid in understanding the scope of the policy is sufficiently available to the new employee(s).

e. All credentials required by potential employees to hold specific positions in the organization will be verified with the primary source prior to employment. Requirements of credentials will be determined through job descriptions, which identify the educational, training credentialing, and/or licensure requirements of each position. HR will note the outcome of the action and place in the employee's personnel folder. If the potential employee does not have a current license or is not in good standing with the licensing board, employment will not occur.

f. In the event that an employee is unwilling or unable to produce the required credentialing documents, he/she will be summoned for an explanation to the Management Team. Upon adequate discovery by this committee that an employee has indeed presented, under signature, a false statement of material fact on an employment application, for any purpose for which that application was presented, the employee will be deemed to have voluntarily forfeited employment.

g. The ACR Clinical Director is responsible for the implementation of this policy within the agency. Supervisors/Managers are responsible for insuring that employees are adequately aware of this policy.

h. Please have college/vocational transcripts mailed to:

Assertive Community Recovery, LLC
Attn: Human Resource Director
4151 Memorial Drive, STE 209C
Decatur, GA 3032

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com
4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

Policy 10.14 - Professional Education Credentials

POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to accept various degrees from Colleges and Universities that are awarded by institutions accredited by the six national accreditation organizations recognized by the U.S. Department of Education.

1. Middle States Association of Colleges and Schools Commission on Higher Education
2. New England Association of Schools and Colleges Commission on Institutions of Higher Education
3. North Central Association of Schools and Colleges, The Higher Learning Commission
4. Northwest Association of Schools, Colleges and Universities Commission on Colleges and Universities
5. Southern Association of Colleges and Schools Commission on Colleges
6. Western Association of Schools and Colleges Accrediting Commission

The Human Resources Office ensures that academic and professional credentials reported as a part of the employment screening and either the promotion, transfer and assignment process are verified. Please refer to Personnel Policy #10.13 – Verification of Credentials.

For additional information please contact the Human Resources Office at 404-508-0078.

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com
4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

Policy 10.15 -Professional Licensing

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to insure that academic and professional credentials reported as a part of the employment screening and either the promotion, transfer and assignment process are permanently reflected in the employees personnel file.

II. PROCEDURES:

A. ACR will retain as permanent record any and all official copies of academic and professional credentials used in the screening process for newly hired employees as well as those used in the screening for promotion, interagency transfer and permanent reassignments. Such evidence of credentials will be retained in the employee's personnel file. The employee's supervisor is responsible for insuring that affected employees are notified of their responsibility to request such documents (official transcripts, certificates, etc.) from the awarding institution(s). The affected employee is also responsible for the expense associated with this requirement.

B. PROFESSIONAL LICENSING

1. All employees in positions which require licenses, certificates or registrations are responsible for ensuring these documents are current.
2. NOTICE

   The Human Resources Representative is to provide an ACKNOWLEDGEMENT OF RESPONSIBILITY TO MAINTAIN CURRENT LICENSE, CERTIFICATE OR REGISTRATION Form (Attachment #1) to applicants/employees selected for employment in positions which require licenses, certificates or registrations.
3. Selected applicants/employees are to submit this completed form, along with a copy of the appropriate license, certificate or registration, to the Human Resources Department on or before reporting to work.
4. These documents are to be maintained in the employee's personnel file located in the Human Resources Department. Verification will be performed by the Human Resources Department in accordance with Policy #10.13 – Verification of Credentials.

C. RENEWAL

1. Employees are responsible for renewing required licenses, certificates or registrations as necessary.

2. Employees are to submit proof of renewal to the Human Resources Department.
3. As part of ongoing performance management, evaluating supervisors are responsible for ensuring that employees under their supervision meet this condition of employment.

D. CONSEQUENCE

1. Failure to obtain or maintain valid licenses, certificates, or registrations is a basis for separation from employment.
2. Although employees are responsible for maintaining current licenses and certifications, the Human Resources Office also maintains this information and informs employees of upcoming expiration dates.
3. For additional information or assistance, please contact the agency's Human Resources Office at 404-508-0078

Attachment #1 -ACKNOWLEDGEMENT OF RESPONSIBILITY TO MAINTAIN CURRENT LICENSE

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

10.16 - Performance Substantially Below Expectations

I. POLICY:

A. It is the policy of ACR that the competency and overall performance of ACR employees shall be maintained at the highest standards .

II. PROCEDURES:

A. Employees receiving an overall ratings of "Substantially Below Requirements" must be re-evaluated as follows:

1) A Performance Plan outlining performance expectations for the next three months must be established by the supervisor within two weeks of the evaluation meeting. This action should be taken even if the original evaluation is under appeal. There shall be in the Development Plan, supervisory review dates to regularly assess the employee toward fulfilling the plan.

   a. The entire Performance Plan should be completed, including the "Developmental Plan." If the Results Expected/ Performance Standards in the original Performance Plan are appropriate, this information should be transferred to a new PE Form.

   b. The supervisor should describe and discuss with the employee specific actions that must be taken to improve performance in order to meet the minimum expectations during the re-evaluation period.

   c. The reviewer, then the employee, must review and sign the new three-month plan.

   d. Copies of the Development Plan shall be distributed as follows:

      1. employee,
      2. supervisor; and
      3. Human Resources Director.

2) These employees should be re-evaluated three months from the date they received their original evaluations. The re-evaluation process will be terminated if these employees initiate and receive transfers to other positions before the end of the three month re-evaluation.

10.16 - Performance Substantially Below Expectations

B. If, upon re-evaluation, overall ratings continue to be below "Fulfills Requirements" the following options may be considered during the next two months:

    1) Lateral transfer to a more suitable position within ACR; or

    2) Demotion to another position within ACR

    3) Should ACR elect not to implement either of the foregoing options these employees shall be discharged from employment with ACR

C. The re-evaluation process does not preclude disciplinary actions based on poor performance using the "Standards of Conduct" and "Performance Evaluation" policies at any time when appropriate.

D. **Removal from Staff from Service**: At anytime that the performance, competency or other attributes/factors of an employee; i.e. competency, accusation of abuse, neglect or exploitation has resulted or may result in negative impacts on service delivered to persons served the following will take place:

    1) ACR Policy 12.06, Alleged or Suspected Abuse and Neglect and ACR Policy 12.09 - Reports of Abuse, Neglect or Exploitation by Staff will be followed.

    2) Within 2 hours of a supervisor becoming concerned about the performance of a employee, the Clinical Director or CEO/Executive Officer will be notified and briefed the nature of the concerns/offense.

    3) Clinical Director/CEO will determine the severity of situation and take appropriate action to prevent further harm or potential harm to persons served; i.e. immediate suspension of the employee until further investigation is completed.

    4) Within 48 hours, the Clinical Director and Program Manager will document the employee's deficiencies and determine if employee should be allowed to have continued direct contact with persons served; if is so with or without supervision and what specific actions/training is needed overcome shortcomings.

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email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

Policy 10.17 - Disciplinary Procedures for Employees

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to establish a disciplinary procedure for employees that is fair, prompt, and supports quality in service delivery to consumers and best practices in counseling and social services.

II. GENERAL GUIDELINES

A. Supervisors have the responsibility to inform employees about job expectations and any relevant information (i.e., rules, policies, etc.) which will assist employees in carrying out job duties. Employees have a responsibility to satisfactorily perform job duties and be familiar with the rules, policies and standards of the workplace. It is especially important that changes in duties or standards be communicated as soon as practicable.

B. Employees are expected to be able to consistently demonstrate competency and necessary skill-set in carrying out their duties in accordance with the best evidenced based practices of their profession.

C. All rules, policies and standards should be consistently enforced. Consistency in enforcement does not mean that the penalty for violation must be precisely the same in every instance. The penalty may vary because of the severity of the offense, presence or absence of intent, the previous work record of the employee or other relevant factors.

D. Supervisors and employees should be aware that it is not necessary or required that every disciplinary action be followed in every situation (i.e., oral reprimand, written reprimand, adverse action). Over a period of time, it may be appropriate to use several approaches, including disciplinary action, to address an employee's problem(s).

E. Discipline should not be administered with the purpose of punishing the employee. The purpose of each action, with the exception of dismissal, should be to immediately correct the inappropriate behavior or performance deficiency.

F. Employees are required to cooperate and provide assistance, when appropriate, with any type of investigation regarding criminal or administrative misconduct.

III. PROCEDURES For Employees:

A. Corrective measures may be appropriate to emphasize inappropriate behavior, lack of competency or performance deficiencies. Examples of corrective measures are:

1. Attendance Plan - outline of specific expectations required of the employee regarding absenteeism.
2. Work Plan - a written statement of specific work expectations. The plan is designed to give the employee the opportunity to raise performance to an acceptable level.

3. Training -The focus of training should be explanation of work rules, policies and procedures. ACR will not provide the technical or professional necessary to is expected of individuals with a specific professional designation; i.e. it is expected that licensed professional hired as a therapist (LCSW, LPC, FMT) will have the evidence- based skills to conduct a therapy session with a consumer and in accordance with their ethical code.

B. Prior to initiating any kind of disciplinary action, the Human Resource Manager must be notified in order to guide the supervisor through the appropriate process. Disciplinary actions include, but are not limited to, the following:

1. Suspensions
2. Oral/Written Reprimands
3. Letters of Expectation
4. Salary Reductions
5. Demotions
6. Dismissals

IV. PROCEDURES FOR CONTRACT EMPLOYEES:

A. As with employees ,corrective measures applied in the case of contract employees may also be appropriate to emphasize inappropriate behavior or performance deficiencies. Examples of corrective measures are:

1. Attendance Plan - outline of specific expectations required of the employee regarding absenteeism.
2. Work Plan - a written statement of specific work expectations. The plan is designed to give the employee the opportunity to raise performance to an acceptable level.
3. Training is not an appropriate action for incompetent contract employ employees who by the nature for accepting a contract position with ACR have stated that they possess the necessary skills and knowledges to fully perform their duties. Contractor may be trained in work rules that particular to ACR.

B. However, with contract employees the only authorized disciplinary action that can be taken is to terminate the employees contract for failure to provide services in accordance with terms of the contract.

V. All employees have the right to appeal adverse/disciplinary actions to the CEO/Executive Officer.

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com
4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

Policy 10.18 - Confidentiality of Personal Information Concerning Employees

I. POLICY:

A. It is the policy of ACR that Personal information maintained by ACR Human Resources concerning an employee is confidential.

B. Personal information includes, but is not limited to, the employee's social security number, home phone number and address, health, retirement, insurance, and benefits information, and other personal information unrelated to the employee's performance of official duties, which if disclosed, would be an invasion of the employee's personal privacy.

C. Confidential personal information concerning an employee is accessible only under the following circumstances:

1. The Human Resource staff has access to the information for custodial purposes.
2. The employee has access to the information.
3. The employee's legal representative may have access to the information, if the employee has provided written, signed authorization for such access.
4. The employee's supervisor, the CEO/Chief Executive Officer, or the CEO/Chief Executive Officer's designees have access to the information when the information is essential for employment related purposes.
5. The Department of Human Resources Office of Fraud and Abuse and the Georgia Bureau of Investigation have access to the information for purposes of investigation of employment related misconduct.
6. The information must be disclosed if required by law. Examples include a subpoena of a court of competent jurisdiction and a request for production of documents as authorized by O.C.G.A. 9-11-34.

A. ACR Human Resource staff are custodians of the confidential personal information and are responsible for compliance with this policy.

B. If confidential personal information concerning an employee is maintained in a file together with information that is not confidential, the confidential personal information shall be removed prior to granting access to the file, unless one or more of the conditions in Section II of this policy is present.

C. Access, which is authorized by this policy, will be permitted during normal work hours of any regular workday. Individuals seeking access should provide advance notice of their intent to review requested material.

D. Individuals seeking access to confidential personal information as authorized by this policy shall provide proper identification before being granted access.

E. Release of Employee Information from Personnel Files

1. Except for the routine processing of payroll, taxes, insurance, and related administrative functions, or as required by law, payroll information will not be released to credit bureaus, banks, or other credit agencies or to any person without the employee's prior written consent. Third party requests for information must be in writing and accompanied by written authorization from the employee. A copy of the written response is maintained in the employee's personnel file.

2. ACR personnel are not permitted to give references unless they are listed as a personal reference. Prior to giving the reference, the individual must verify that his/ her name was used as a personal reference. In such instances, ACR assumes no responsibility for any information given.

3. All employment-related verifications/ requests are to be handled by the Human Resources Director. The following information will be provided when requested by telephone or in writing: (1) beginning and ending dates of employment; (2) verification of current salary; and (3) job title. No additional information may be provided to prospective employers or any other party unless required by law.

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

Policy 10.19 - Competency Assessment

I. POLICY:

A. It is the policy of ACR to assure that its staff and contractors are informed and capable regarding the knowledge, skills and abilities necessary to fulfill their respective job descriptions, employment criterion, specifications, and clinical privileges. Competency is dynamic and moves along a continuum of education and experience. It varies by job description and designated responsibilities. In addition, however, certain knowledge and skills must be demonstrated by all staff and contractors. This common body of knowledge, together with the uniform administration of competency assessment, is outlined in these procedures..

II. PROCEDURES:

A. Competency Requirements

1. By the end of the "new employee orientation period", the new staff members must demonstrate:
    a) familiarity with the ACR's mission, vision and value statement;
    b) knowledge and competency defined in his/her job description and presumed as the basis for hiring; and
    c) familiarity and compliance with the ACR's standards of employee conduct and professionalism.
2. On an annual basis, according to schedules developed by the HR Office, staff member must:
    a) attend mandatory training classes for the appropriate staff category;
    b) obtain a satisfactory rating on all competency checklists in field files,
    c) obtain a satisfactory rating on his/her performance evaluation.
3. On a continuing basis, the staff member must maintain competence by means of one or more of the following:
    a) participation in departmental staff meetings;
    b) participation in departmental or cross-departmental projects (e.g., performance improvement);

c) attendance at outside seminars related to specialty information or position-specific knowledge topics;

d) completion of educational credits related to licensure or certification;

e) departmental training; and

f) self-study.

B. Competency Process

1. Applicants are assessed initially during the interview process and continued through general and unit/department orientation. Competent staffing is ensured by the Performance Management Plans as described in ACR Policy #10.08 -Employee Performance Evaluation. The Plans are evaluated periodically in conjunction with the performance review process and improved through ongoing education based on needs assessments and review of aggregate data findings.
2. Program managers will provide each new employee with a Performance Management Plan (PMP) that is detailed on a Performance Evaluation Form within forty- five (45) days of employment, re-assignment or promotion.
3. The Performance Evaluation Form (PEF) details individual job responsibilities and expectations for the position assignment. Each employee's performance is monitored on an on-going basis.
4. Managers maintain a field file on each employee and establish dates for periodic reviews. These files are made accessible to the employee for their review.
5. Information documented in the field file should be used by the evaluating manager in completing interim and annual reviews, using the Management Review Form (MRF). The MRF must be completed for each employee each mid-year of the evaluation period and at the end of six (6) months for each employee during the working period.
6. Managers document assessment of skills, equipment use, and credential requirements on Competency Assessment Forms during unit/program orientation, annually, or on an as needed basis. The required competencies and the methods used to assess those competencies will be verified on the Competency Assessment Form and maintained in the field file. Age Specific Competencies are identified on the PEF and used for Performance Evaluations to determine Competency in this area.
7. Managers must submit a completed Performance Management Form, or Management Review Form to the Personnel Section at the designated

time. The signature of the Program Manager on the Employee Competency Checklist verifies the completion of all components of the Employee Performance Management Plan.

8. Any employee who receives a “did not meet” for any Responsibilities /Expectations during the annual evaluation process, will be provided with an Employee Development Plan that includes, goals for areas of improvement. These actions will be monitored by the manager during a specific time frame for completion. At the end of the plan period, a decision will be made concerning the employees continued employment. Tools that may be used include in-service training, coaching or on the job instructions.

C. Analysis of Staff Competence includes the following:

1. Collection of Aggregate Data
    a) 1. Human Resource Manager maintains a tracking system that supports continuing competency
    b) and provides managers with authenticity of required training.
    c) 2. Aggregate data will be statistically analyzed and trended by department and job
    d) class.
2. Use of Competency Assessment Data
    a) Data will be utilized to assess staff learning needs.
    b) Data will be utilized to plan in-service education, training, and/or other teaching methods to address learning needs.
    c) Data analysis results will be submitted to the Leadership Team for performance improvement activities and strategic planning.
    d) Competence assessment results will be submitted at least annually to the Leadership Team.

Attachment: Competency Assessment Checklist (Available in the Human Resources.)

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

Policy 10.20 - Staff Education and Training

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) that the primary goal of a staff development program is to enhance the ability of a program to perform the functions and activities for which it is responsible. Once the manpower needs of the program are identified, methods for meeting those needs can be established, and it is essential that those methods be consistent with the need. One excellent way the program can fulfill its staffing needs is to augment the skills and knowledge base of its staff for which they were hired or to accept new responsibilities, which may be outside of their sphere of activity. It is critical that the competence of the staff be continually developed and improved so that the program's activities can be provided effectively, efficiently, and with the highest possible level of quality.

II. PROCEDURES:

A. Every effort should be made by the Leadership Team to continuously monitor and assess the need for education and/or training activities consistent with the needs of the program and its staff.

B. At least annually, the Leadership Team shall identify and recommend staff training and education activities of benefit to their program.

C. Education and training activities should include CEO, as well as staff.

D. **Staff Orientation:** All staff members will be given a orientation prior to having direct contact with consumers. This orientation will include at the minimum the following:

- The purpose, scope of services, supports, care and treatment offered including related policies and procedures;
- Confidentiality of individual information, both written and spoken;
- Rights and responsibilities of individuals;
- Requirements for recognizing and reporting suspected abuse, neglect or exploitation of any individual:
    a. To the Department of BHDD;
    b. Within the organization;
    c. To appropriate regulatory or licensing agencies;
    d. To law enforcement agencies.

E. **Within 60 days of hire,** all staff having direct contact with consumers shall receive the following training including, but not limited to

- Person centered values, principles and approaches;

- Holistic care of the individual
- Medical, physical, behavioral and social needs and characteristics of the persons served;
- Human rights and responsibilities (*);
- Promoting positive, appropriate and responsive relationships with persons served and their families;
- The utilization of:
    a. Positive communication (*);
    b. Positive behavioral supports based on science of applied behavior analysis (*); and
    c. Crisis intervention techniques to de-escalate challenging and unsafe behaviors (*);
- Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization);
- Ethics, cultural preferences and awareness;
- Fire safety (*);
- Emergency and disaster plans and procedures (*);
- Techniques of standard precautions, including:
    a. Preventative measures to minimize risk of HIV;
    b. Current information as published by the Centers for Disease Control (CDC); and
    c. Approaches to individual education.
- Basic cardiac life support (BCLS);
- First aid and safety.
- Common and specific individual medications and their side effects (*);
- Service, support, care and treatment specific topics appropriate to the care of persons served, such as but not limited to:
    a. Symptom management;
    b. Principles of recovery relative to individuals with mental illness;
    c. Principles of recovery relative to individuals with addictive disease;
    d. Principles of recovery and resiliency relative to children and youth; and
    e. Relapse prevention.

F. **Annual Training:** All staff, contractors, and volunteers are required to attend at least sixteen (16) hours of training annually that enhances their ability to meet the needs of the consumer. Independent contractors must provide certification of additional training prior to renewal of contract agreement. This training is identified by the asterisk (*) in E. above and listed below:
    - Crisis Prevention Intervention
    - Basic cardiac life support (CPR), first aid and safety.
    - HIPPA
    - Universal Precaution
    - Cultural Diversity
    - Guidelines for Supporting Adults with Challenging Behaviors in Community Setting

- Consumer Rights and Responsibilities
- Medicaid Fraud
- Ethics and Cultural Competence

G. Required Training by Persons in Specific Job Positions:

1. **Paraprofessionals**: Essential Learning by all Paraprofessionals and non-credentialed bachelor and master level contractors and/or employees in accordance with DHR Policy:
   - Abuse, Neglect, and Incident Reporting for Paraprofessionals
   - Alcohol and the Family for Paraprofessionals
   - Case Management Basics for Paraprofessionals
   - Co-Occuring Disorders: An Overview for Paraprofessionals
   - Coordinating Primary Care Needs for Paraprofessionals
   - Corporate Compliance and Ethics for Paraprofessionals
   - Crisis Management for Paraprofessionals
   - Cultural Diversity for Paraprofessionals
   - Defining Serious and Persistent Mental Illness and Recovery
   - Essential Components of Documentation for Paraprofessionals
   - In Harms Way
   - Medication Administration & Monitoring for Paraprofessionals
   - Mental Health Issues in Older Adults for Paraprofessionals
   - Mood Disorders in Adults – A Summary for Paraprofessionals
   - Overview of Bipolar Disorder for Paraprofessionals
   - Overview of Family Psychoeducation – Evidenced Based Practices
   - Overview of Medication for Paraprofessionals
   - People with Serious Mental Illness for Paraprofessionals
   - Suicide Prevention
   - Suicide The Forever Decision
   - Supported Employment – Evidenced Based Practices
   - Therapeutic Boundaries for Paraprofessionals
   - Understanding Schizophrenia for Paraprofessionals
   - Understanding the Addictive Process: An Overview for Paraprofessionals
   - Other training:
     - Skill Building
     - ADL's skill
     - Community Linkage
     - Assertive communication training
     - Identifying risk factors

2. CPS workers:
- Developing WRAP Plans
- Goal setting with consumers
- Social Skill building
- Advocacy

- Problem solving techniques
- Communication skills training
- Teaching recovering skills

3. **Licensed and Clinical staff:**
   - Person Centered Planning
   - Crisis intervention, crisis stabilization, and screening
   - Screening and developing suicide contract
   - Symptom Identification Management
   - Common and specific consumer medication and their side effects.
   - Relapse Prevention
   - Treatment modalities
   - Discharge Planning

4. **Substance Abuse Professional:**
   - Screenings/Intake
   - Treatment Planning
   - Case Management
   - Referral

5. **Licensed Professionals/Certified Staff:**
   Must meet the Continuing Education Requirements of their professional licensing board and provide proof to ACR Human Resources that necessary training was accomplished.

Assertive Community Recovery will ensure that at all times and on all occasions, universal precautions are practiced. Staff in positions at risk of exposure to HIV will receive periodic continuing education on preventative measures, current information, and approaches to consumer education.

All staff or independent contractors, who have direct contact with consumers, are involved in development of the provider's programs of service and support, or participate in the development of individual consumer service/support plans, will have training in Ethics and Cultural Competence and Appropriateness.

Staff or contractors, who are involved in development of the provider's programs of service and support, have training in "best practices" as well as new technologies in service delivery.

Additional training may consist of Medicaid and HIPPA updates to the procedures as needed and/or required.

POLICY 10.21- Business Associates

POLICY:

Any vendor or independent contractor who proposes to do business with Assertive Community Recovery, LLC (ACR) will be subjected to procedures that will determine if the vendor or subcontractor is a Business Associate. We will consider any vendor or independent contractor to be a Business Associate if they have the following characteristics:

1. They perform a function or activity on our behalf that involves the use or disclosure of PHI or provide any legal, actuarial, accounting, consulting, data aggregation or management, administrative, accreditation, or financial services to or for us;

2. They are not involved in the treatment of a client; and

3. They are not providing consumer-conducted financial transactions.

Any vendor or independent contractor (but not any member of our workforce) who qualifies as a Business Associate will be required to sign a Business Associate Agreement. The Agreement will be in the form attached to this policy.

Amendments to the Business Associates Agreement may not be made without the approval of legal counsel.

Protection of our client's health information is important to us, therefore we require our employees to be sensitive to the behavior of our Business Associates and to report any conduct that appears inappropriate.

Definition: For the purpose of this policy, **protected health information** (PHI) means any individually identifiable health information collected or stored by a facility. **Individually identifiable health information** includes demographic information and any information that relates to past, present or future physical or mental condition of an individual.

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

BACKGROUND / PURPOSE:

The HIPAA Privacy rules identify a new category of business relationship, called a "business associate." The purpose of this policy is to specify when Assertive Community Recovery, LLC (ACR) may disclose an individual's protected health information to a business associate of ACR, and to specify provisions that must be included in ACR contracts with business associates.

IMPLEMENTATION / PROCEDURE:

A. Definition of "Business Associate"

1.With respect to ACR, "Business Associate" means (per 45 CFR 160.103) a person or entity who:

a. On behalf of ACR, but other than in the capacity of a ACR employee, performs or assists in the performance of:

i. function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing benefit management, practice management, and repricing; or

ii. Any other function or activity regulated by federal regulations at 45 CFR Subtitle A, Subchapter C; or

b. Provides, other than in the capacity of a ACR employee, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for ACR, or for an organized health care arrangement in which ACR participates, where the provision of the service involves the disclosure of individually identifiable health information from ACR, or from another business associate of ACR, to the person.

2.A business associate relationship is formed only if protected health information is to be used, created, or disclosed in the relationship.

3.The following are **not** business associates or business associate relationships:

a. ACR employees, offices, and programs;

b. Medical providers providing treatment to individuals;

c. Enrollment or eligibility determinations, involving ACR clients, between government agencies;

d. Payment relationships, such as when ACR is paying medical providers, child care providers, managed care organizations, or other entities for services to ACR clients or participants, when the entity is providing its own normal services that are not on behalf of ACR;

e. When an individual's protected health information is disclosed based solely on an individual's authorization;

f. When an individual's protected health information is not being disclosed by ACR or created for ACR; and

g. When the only information being disclosed is information that is de-identified.

4 .ACR may disclose an individual's protected health information to a business associate and may allow a business associate to create or receive an individual's protected health information on behalf of ACR, if:

a. ACR first enters into a written contract, or other written agreement or arrangement, with the business associate before disclosing an individual's protected health information to the business associate, in accordance with the requirements of

Section 2,below, of this policy.

b. The written contract or agreement provides satisfactory assurance that the business associate will appropriately safeguard the information.

B. Contract Requirements Applicable to Business Associates

1. A contract between ACR and a business associate must include terms and conditions that:

a. Establish the permitted and required uses and disclosures of protected health information by the business associate. The contract may not authorize the business associate to further use or disclose health information obtained from ACR, except that the contract may permit the business associate to use and disclose protected health information for the proper management and administration of the business associate; and collect data relating to ACR operations.

b. Provide that the business associate will:

i. Not use or further disclose protected health information other than as permitted or required by the contract or as required by law;

ii. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the contract;

iii. Report to ACR any use or disclosure not allowed by the contract of which the business associate becomes aware;

iv. Ensure that any agents or subcontractors to whom it provides protected health information agrees to the same restrictions and conditions that apply to the business associate under the contract;

v. Makes its internal practices, books, and records relating to the use and disclosure of protected health information available to ACR and to the United States DHHS for the purpose of determining ACR's compliance with federal requirements;

vi. At termination of the contract, if reasonably feasible, return or destroy all protected health information that the business associate still maintains in any form, and keep no copies thereof. If not feasible, the business associate will continue to protect the information.

c. Authorize termination of the contract if ACR determines that the business associate has violated a material term of the contract.

2. If the business associate of ACR is another governmental entity:

a. ACR may enter into a memorandum of understanding, rather than a contract, with the business associate if the memorandum of understanding contains terms covering all objectives of this policy as defined above;

b. The written contract, agreement, or memorandum does not need to contain specific provisions required under B 1 above, if other law or regulations contain requirements applicable to the business associate that accomplish the same objective;

3. If a business associate is required by law to perform a function or activity on behalf of

ACR, or to provide a service to ACR, ACR may disclose protected health information to the business associate to the extent necessary to enable compliance with the legal requirement, without a written contract or agreement, if:

a. ACR attempts in good faith to obtain satisfactory assurances from the business associate that the business associate will protect health information to the extent specified in B 1 above; and

b. If such attempt fails, ACR documents the attempt and the reasons that such assurances cannot be obtained;

4. Other requirements for written contracts or agreements: The written contract or agreement between ACR and the business associate may permit the business associate to:

a. Use information it receives in its capacity as a business associate to ACR, if necessary either for proper management and administration of the business associate or to carry out the legal responsibilities of the business associate.

b. Disclose information it receives in its capacity as a business associate if the disclosure is required by law or the business associate receives assurances from the person to whom the information is disclosed that:

i. It will be held or disclosed further only as required by law or for the purposes to which it was disclosed to such person; and

ii. The person notifies the business associate of any instances of any known instances in which the confidentiality of the information has been breached.

C. Responsibilities of ACR in Business Associate relationships

1. ACR responsibilities in business associate relationships include, but are not limited to, the following:

a. Providing business associates with a copy of the Privacy Practices Notice currently in force (Form 114)

b. Receiving and logging an individual's complaints regarding the uses and disclosures of protected health information by the business associate or the business associate relationship;

c. Receiving and logging reports from the business associate of possible violations of the business associate contracts;

d. Implementation of corrective action plans, as needed; and

e. Mitigation, if necessary, of known violations up to and including contract termination.

2. ACR will provide business associates with applicable contract requirements, and may provide consultation to business associates as needed on how to comply with contract requirements regarding protected health information.

D. Business Associate non-compliance

1. If ACR knows of a pattern of activity or practice of a business associate that constitutes a material breach or violation of the business associate's obligation under the contract or other arrangement, ACR must take reasonable steps to cure the breach or end the violation, as applicable, including working with and providing consultation to the business associate.
2. If such steps are unsuccessful, ACR must:
    a. Terminate the contract or arrangement, if feasible; or
    b. If termination is not feasible, report the problem to the United States DHHS and DHR DBHDD.

Policy 10.22 - Documentation Standards and Progress Note Submission

I. POLICY:

All services must be provided according to federal, state and agency guidelines / regulations and must be properly documented. Documentation must be legible, grammatically correct, typed in proper format, submitted on the dates requested, and must verify that services rendered were ethical, clinically appropriate, and assisted individual(s) with the attainment of identified treatment goals and / or objectives. Documentation includes, but is not limited to, progress notes, treatment plans, invoices, and consent forms.

II. PROCEDURES:

A. Full payment for untimely submitted and / or improperly written documentation cannot be guaranteed by the agency due to our inability to bill for these services within the scheduled timeframe. A delay in billing for services rendered by staff is problematic for our agency due to the fact that is that it hinders our ability to maintain organizational standards and meet all our financial obligations. With this in mind, it is necessary to implement a policy for clinical documentation submitted late and / or improperly written documentation.

B. All Clinical Documentation is due **within 3 days after service delivery.**

C. Supervisory controls will be established to assist staff members in meeting ACR Quality Standards and time requirements for clinical documentation submission.

D. The date of the signature on all clinical documentation to include the Electronic Medical Record (EMR) ShareNote Progress Notes **must be the date that the note was actually signed**. Adjustments have been made to the ShareNote EMR system that prevents staff members from backdating or postdating progress notes. Staff members who continue to fail in completing clinical documentation in accordance DBHDD and ACR's Documentation Standards will be subject to corrective action plans to improve the staff member performance and ensure compliance with this directive. Continue failure to date clinical documentation correctly may result in termination.

E. **Within 3 days of Service Delivery** staff is required to submit locked and signed clinically sound documentation that reflects their credentialing and training.
   a. Notes must be Locked/Sign by user on Submission.
   b. **The date of the signature will be date generated by the system when the system is signed. ShareNote has been changed to prevent note writers from changing the signature date.**
   c. **Staff can now save a note in progress. However, notes no longer can be submitted without being locked and signed. Only locked and signed notes will be read for approval.**

F. **Quality Assurance Reviews take will within 48-hours submitting your note except for weekends and holiday periods. Notes submitted on weekends and holiday periods will**

be read by the second business day after the two-days weekends and holiday period. This being done so that we can ensure that notes are filed in individual charts within the DBHDD guidelines and with compliance with billing standards. Notes will be read daily.

G. Notes will not be placed in a review status for minor errors; things that can be corrected by using the DBHDD allowed error correction method, (spacing a single line through the error, writing the word "error" and adding the correct information, initials and date of the correction). This will require printing out the note so that the original signature and date will be maintained, after the error is corrected the note scanned and uploaded to ShareNote.

H. Staff must correct, lock and sign any notes placed in reviewed by the 6th day following service delivery.

I. Notes will no longer be penalized if submitted or if necessary corrected, locked and signed by the 7th day following service delivery. Any notes not locked and signed and not approved by the 7th after service delivery will be paid at minimum wage. Be mindful, if the staff member submits the note on the 7th day and if when the note is read, the note is put into review due errors/omissions committed by the staff member that note will be paid at minimum wage.

J. Also, please note that frequent submission of documentation after the due date will result in further actions being taken by management, up to or including termination. **Please read these pages in their entirety and sign below to show that you have read and fully understand this new policy/ procedure and retain a copy of this memo for your records. This policy/ procedure will become effective immediately.**

K. This policy is written to remind staff of what is expected of them. It is written in an attempt to ensure that documentation is completed and to ensure that we are continuing to provide our individuals with quality, individualized services in a timely manner. We believe that all staff members are capable of meeting all deadlines and pride themselves in providing effective intervention to individuals and their families in an effort to assist them with making lasting behavioral changes. As always, your hard work and perseverance is greatly appreciated. If there are any questions about this or related matter, please feel free to contact your supervisor. Thank you in advance for your cooperation

By signing below, I acknowledge that I was given an opportunity to read and ask questions for clarity and understanding of the above policy. I also I was given a copy of this policy and ACR's 11.02 Electronic Signature Policy.

_____

Employee Signature

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

Policy 10.23 - Conflicts of Interest

PURPOSE:

Assertive Community Recovery, LLC (ACR), officers, directors, administrative staff, clinical staff including all full-time, part-time, contractors and volunteers, shall exercise the utmost good faith in all transactions related to their ACR job duties, consumers and property. In their dealings with and on behalf of ACR, they shall be held to a strict rule of honest and fair dealing and must be alert in conducting business with non-employees to avoid even the appearance of misconduct, personal or financial gain or conflict of interest. They shall not use their positions, or knowledge gained so that a conflict might arise between their own interest and those of ACR. All acts by every employee, contractor or volunteer shall be for the best interest of ACR.

POLICY: Conflicts of interest are avoided and where discovered, immediately Corrected; and whenever appropriate or necessary, a signed release of information is obtained. ACR will use the following procedures to identify potential conflicts and to resolve any questions that arise about the interests of an employee, contractor or volunteer:

PROCESS:

1. All new personnel shall review and receive the Conflicts of Interest policy during orientation. Personnel already employed or contracted at the time this policy goes into effect shall be trained in corporate compliance.

2. All personnel shall sign the Statement of Understanding of Conflicts of Interest policy.

3. All personnel will be asked to complete a Disclosure of Interests and Affiliations form annually and to update it according to changing circumstances.

4. The Office Manager will review all forms. Any forms containing a positive response will be forward and reviewed by the Leadership Team for consideration.

5. If the Leadership Team determines that interests and activities of an employee/contractor are in direct conflict with the interests of ACR and/or individuals served, the Office Manager

may ask that the employee/contractor remove him or herself from any activities related to those interests.

Employee/Contractor Name: _____

Position: _____

A conflict of interest, or an appearance of a conflict, can arise whenever a transaction, or an action, of Assertive Community Recovery conflicts with the personal interests, financial or otherwise, of that of an employee/contractor.

Please describe below any relationships, transactions, or positions you hold (volunteer or otherwise), or circumstances that you believe could create a conflict of interest , currently or in the future, between Assertive Community Recovery and your personal interests, financial or otherwise:

_____ I have no conflict of interests to report.

I have the following conflict of interests, or potential conflicts of interests, to report:

1._____

2._____

3._____

4. _____

I have reviewed Assertive Community Recovery's Conflict of Interests policy and I understand that it is my obligation to disclose a conflict of interests, or appearance of a conflict, to the Office Manager when a conflict, or appearance of a conflict, arises.

Signature: _____ Date: _____

Policy 10.24 - Federal Funding and Corporate Compliance for Excluded Individuals/Entities - LEIE

PURPOSE

This policy establishes the standards by which ACR Health Services screens all workforce members, contractors and vendors for restrictions on their ability to participate in federal and state healthcare programs and contracts.

POLICY

ACR Health Services does not hire, grant privileges to, contract with or bill for services rendered by the individuals and vendors who are excluded, debarred, suspended or otherwise declared ineligible to participate in federal or The State of Georgia healthcare programs or contracts.

I. Initial Hiring, Credentialing, and Contracting

Prior to hiring or privileging/credentialing an individual or contracting with a vendor, ACR Health Services screens the individual or organization against the applicable federal and state exclusion lists, including:

- Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)at: https://exclusions.oig.hhs.gov/

and

- U.S. General Service Administration (GSA) System for Award Management (SAM) at: https://www.sam.gov/

and

- Georgia Office of Inspector General (GA OIG) Medicaid Exclusion List at https://dch.georgia.gov/georgia-oig-exclusions-list

II. Ongoing Screening

After initial hiring, privileging/credentialing or contracting, exclusion screening using the three exclusion lists (OIG, GSA and GA OIG) is completed monthly.

III. Notification Responsibilities

A. ACR Health Services includes language in its contracts that require vendors to comply with the law to disclose information regarding exclusions from federal healthcare programs.
B. It is the responsibility of each workforce member, contractor and vendor to provide immediate notice to ACR Health Services upon being (A) excluded, debarred, suspended or otherwise declared ineligible to participate in federal or state healthcare programs or contracts; (B) convicted of a criminal offense as defined by 42 U.S.C. § 1320a-7(a).

IV. Exclusions

If a workforce member, contractor or vendor has been excluded, debarred, suspended or otherwise declared ineligible to participate in federal healthcare programs or contracts or found to be convicted of a criminal offense as defined by 42 U.S.C. § 1320a-7(a), the appropriate ACR Health Services program directors are notified for further review and action as necessary to include:

1. Immediate removal of the workforce member or vendor from direct or indirect responsibility for, or involvement in, any federal or state-funded healthcare program until (a) the issue is resolved and (b) it is determined the individual or vendor is not excluded, debarred, suspended or otherwise ineligible to participate in federal or state healthcare programs;
2. Repayment of claims for services in which the excluded individual, to include workforce members, or vendor, participated. For the purpose of this policy, "participated" means ordered, referred, provided or supported the service.
3. Termination of the workforce member, contractor or vendor.
4. Notifying Georgia OIG that an ACR workforce member, contractor or vendor was discovered to be on the exclusion list:

   Georgia Department of Community Health
   Medical Assistance Plans
   Provider Enrollment Section
   2 Peachtree Street NW, 37th Floor
   Atlanta, GA 30303
   Telephone: (404) 651-5191
   Fax: (404) 463-1118

V. Document Retention

ACR Human Resources will maintain appropriate for the exclusion screening process and findings

Policy 10.25 - Disciplinary Action and Termination Guidelines for Appropriate Conduct/Ethical Behavior

I. POLICY:

A. It is the policy of ACR Health Services to promote high standards of ethical behavior and workplace conduct as it is best for the individuals served, our agency and most importantly the employees of ACR. Our ability to serve individuals/families and attract quality employees depends on this reputation The actions of employees may enhance, maintain, or damage the standing that ACR has developed. Therefore, it is expected all employees to exercise the highest standards of ethics in all of your decisions that may impact ACR Health Service.

B. No workplace conduct statement can possibly cover every circumstance that may arise. Use good common sense. Ask yourself if you would like to read about your behavior in the newspaper or see a story about it on the nightly news. If there is any question about a course of action, it is your responsibility to get clarification from senior management.

II. PROCEDURES

C. Conflict of Interest

1) In making decisions, all employees of ACR Health Services must exercise independent judgment that is in the best interest of ACR Health Services. Personal or outside interests or relationships must not influence employees to the detriment of ACR Health Services. ACR Health Services requires that employees protect Agency information and avoid outside activities or relationships, which do or could adversely influence their decisions or actions on the job.

2) Employees must not engage in any activities or relationships, including personal investments, which might directly or indirectly result in a conflict of interest, or impair their independence of judgment. They must not accept gifts, favors, or benefits that might tend in any way to influence them in the performance of their duties.

D. Confidential Information

1) Disclosure of confidential information might seriously damage ACR Health Services or individual served and therefore such action will not be tolerated. This non-disclosure applies during and after an employee's employment. Any copying, reproducing, or distributing of confidential information in any manner must be authorized by management.

Confidential information remains the property of the employer and must be returned to ACR Health Services on demand.

E. Discipline/Discharge

1) Occasionally performance or other behavior falls short of our standards and/or expectations. When this occurs, management takes action, which in its opinion seems appropriate.

2) Disciplinary actions can range from a formal discussion with the employee about the matter to immediate discharge. Action taken by management in an individual case does not establish a precedent in other circumstances.

F. Separation of Employment

1) Georgia is an "employment-at-will" state, which means that an employer or employee may generally terminate an employment relationship at any time and for any reason. However, we request that all employees and contractors consider the impact of sudden departures on the individuals/families served.

2) We request that employees who wish to resign their positions notify ACR Health Services of their anticipated departure date and go over the "check out" procedures at separation (return of property, delivery of final paycheck, etc.) with Human Resources.

3) Employees may be considered for re-employment provided they qualify for the position of interest and while they were employed with ACR Health Services maintained satisfactory performance and attendance.

G. Whistleblower

1) This Whistleblower policy is designed to provide a mechanism for employees and other organization leaders to raise good faith concerns regarding suspected violations of law or Agency policy; to facilitate cooperation in any inquiry or investigation by any court, agency, law enforcement, or other governmental body; and to protect individuals who take such action from retaliation or any threat of retaliation by any other employee or agent of ACR Health Services.

2) This Policy applies to all Agency employees, including part-time, temporary, and contract employees, as well as directors, officers, and other organization volunteers.

3) ACR Health Services is committed to maintaining a workplace where employees are free to raise good faith concerns regarding ACR Health Services' business practices. Employees are expected to report suspected violations of the law on the part of ACR Health Services; to identify potential violations of Agency policy, including those contained in the

employee handbook; and to provide truthful information in connection with any official inquiry or investigation.

4) ACR Health Services expressly prohibits any form of retaliation, including harassment, intimidation, adverse employment actions, or any other form of retaliation, against employees who in good faith raise suspected violations of law, cooperate in inquiries or investigations, or identify potential violations of Agency policies. Any employee who engages in retaliation will not be tolerated.

5) Reports of suspected violations of law or policy and reports of retaliation will be investigated in a manner intended to protect confidentiality, as much as possible. The Quality Assurance and Compliance Director will typically manage such investigation, and may request the assistance of counsel or other outside parties as he or she deems necessary. The Quality Assurance and Compliance Director will typically prepare a report of the findings of the investigation, and submit such report to the Executive Director and CEO.

6) In the event that a report concerns the Quality Assurance and Compliance Director, he or she shall recuse himself or herself from the proceedings, and the Board of Directors shall select an appropriate officer of ACR Health Services to continue the investigation.

7) Any employee who believes that he or she has been subjected to any form of retaliation as a result of reporting a suspected violation of law or policy should immediately report such incident to his or her supervisor, the Quality Assurance and Compliance Director, or the Director of Human Resources. Supervisors, managers, and Human Resources staff who receives complaints of retaliation must immediately inform the Quality Assurance and Compliance Director.

Policy 10.26 - Job Posting Policy and Procedure

POLICY: It is the policy of ACR Health Services to ensure equal employment opportunity for all without regard to age, race, color, gender, national origin, religion, disability, or any other characteristic unrelated to effective job performance.

INTENT: Allow the opportunity for all staff members to apply for open positions to promote better work performance, enhance morale, and create individual achievement and recognition. Additionally, ACR Health Services may offer the same opportunity to external candidates.

PROCEDURE: Job postings will be communicated in an area that has visibility to internal staff members and may be advertised externally (at the discretion of the leadership team). There will be a time limited status on the job posting and ACR Health Services has the right to remove the posting at any time. ACR Health Services reserves the right to select, at its sole discretion an outside candidate for open positions.

In order to apply for a posted position;

a) Candidate must have required skills,
b) Have been in your current position for a minimum of 6 months to 1 year,
c) Have satisfactory job performance, attendance, and punctuality, and
d) Meet requirements in regards to education, licensure, and experience.

- Interviewing will commence in order to establish minimum qualifications; staff lacking qualifications will be notified. Those candidates selected for further consideration, will interview with the leadership team.
- Decision notification will be made after selection occurs and all candidates interviewed will be notified of the final decision.
- There will be a transition period for departments involved as well as for training purposes. Ideally, 2 weeks of training and preparing will ensue in order to support restructure; however, timelines will be adjusted based on needs of ACR Health Services.

Policy 10.27 - Exit Interview

ACR recognizes the sire and need to retain qualified employees n der to provide quality services to its customers. In an effort to assess employee work experiences, feedback from employees who resign from ACR employment should be solicited, evaluated, and used as the basis for workplace improvements.

GENERAL PROVISIONS

1. AN ACR Exit Interview Questionnaire has been developed for use in collecting work experience information.
2. Every mployee ho esigns om ACR employment must be provided an opportunity to complete an Exit Interview Questionnaire.
3. The Exit Interview Questionnaires will be reviewed by the Human Resources Office and will provide summary data to the Performance Improvement Department. The Directors will be available to assist with improvement actions or plans resulting from review of the data.

PROCESS

1. Employees who provide notice of resignation from employment must be informed as soon as possible of the exit interview questionnaire. The employee's manager or personnel representative will provide information to assist the employee with the exit interview process.

2. The information provided by employees will be reviewed by Human Resources and Deputy Directors and may be used to identify trends and make recommendations for improvement plans or other actions.

3. The exit interview is conducted by a human resources representative, or the employee may choose to complete the Exit Interview Form (See Attachment #1) and submit to the Human Resources Department.

4. A quarterly Exit Interview Analysis (See Attachment #2) is completed by the human resources representative and submitted to the Performance Improvement Department. Pertinent comments made by departing employees will be discussed with appropriate management personnel in order to improve and update our policies and procedures.

For additional information or assistance, please contact the agency's Human Resources Office at 404 508 0078

Attachment *EXIT INTERVIEW QUESTIONNAIRE*

Attachment *QUARTERLY EXIT INTERVIEW ANALYSIS*

_____ _____

Frank S. McAllister Date
CEO/Executive Director

Policy 10.27 - Drug-Free Workplace

A. **POLICY:** Assertive Community Recovery, LLC (ACR) prohibits the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in the workplace, but recognizes addiction is an illness and encourages employees to voluntarily seek help with alcohol or drug problems.

B. **PURPOSE:** To ensure the health and safety of ACR's clients/members, employees, and the public.

C. PROCEDURE:

1. ACR will communicate this policy to all employees at the time of hire.
2. Employees will sign the Drug-Free Workplace Acknowledgement at the time of hire.
3. Management will file the original of the acknowledgement form in the employee's personnel file and give a copy to the employee for their records.
4. Refer to Employee Substance Abuse and Drug Testing policy for details regarding procedures for testing.
5. Employees must notify management, as a condition of employment, in writing within five calendar days, if they are convicted of violating a criminal drug statue.
6. Appropriate personnel action will be taken within 30 calendar days, against any employee convicted of violating a criminal drug statue up to and including termination, or will require employee to participate satisfactorily in a Federal, State, Local, or Law Enforcement approved drug abuse assistance or rehabilitation program.
7. Federal agencies will be notified in writing, within 10 calendar days, if any employee engaged in the performance of an award is convicted of violating a criminal drug statue.

Policy 10.28 - Employee Substance Abuse and Drug Testing policy

Purpose

In compliance with the Drug-Free Workplace Act of 1988, ACR Health Services has a longstanding commitment to provide a safe, quality-oriented and productive work environment. Alcohol and drug misuse poses a threat to the health and safety of ACR Health Services employees and to the security of the company's equipment and facilities. For these reasons, ACR Health Services is committed to the elimination of drug and alcohol use and misuse in the workplace.

Scope

This policy applies to all employees and all applicants for employment of ACR Health Services. The human resource (HR) department is responsible for policy administration.

Employee Assistance

ACR Health Services will assist and support employees who voluntarily seek help for drug or alcohol addiction before becoming subject to discipline or termination under this or other ACR Health Services policies. Such employees will be allowed to use accrued paid time off, placed on leaves of absence, referred to treatment providers and otherwise accommodated as required by law. Employees may be required to document that they are successfully following prescribed treatment and to take and pass follow-up tests if they hold jobs that are safety-sensitive or require driving, or if they have violated this policy previously. Once a drug test has been initiated under this policy, unless otherwise required by the Family and Medical Leave Act or the Americans with Disabilities Act, the employee will have forfeited the opportunity to be granted a leave of absence for treatment, and will face possible discipline, up to and including discharge.

Employees should report to work fit for duty and free of any adverse effects of illegal drugs or alcohol. This policy does not prohibit employees from the lawful use and possession of prescribed medications. Employees must, however, consult with their doctors about the medications' effect on their fitness for duty and ability to work safely, and they must promptly disclose any work restrictions to their supervisor.

Work Rules

1. Whenever employees are working, are operating any ACR Health Services vehicle, are present on ACR Health Services premises or are conducting company-related work offsite, they are prohibited from:
    . Using, possessing, buying, selling, manufacturing or dispensing an illegal drug (to include possession of drug paraphernalia).
    a. Being under the influence of alcohol or an illegal drug as defined in this policy.
    b. Possessing or consuming alcohol.
2. The presence of any detectable amount of any illegal drug, illegal controlled substance or alcohol in an employee's body system, while performing company business or while in a company facility, is prohibited.
3. ACR Health Services will also not allow employees to perform their duties while taking prescribed drugs that are adversely affecting their ability to perform their job duties safely and effectively. Employees taking a prescribed medication must carry it in a container labeled by a licensed pharmacist or be prepared to produce the container if asked.
4. Any illegal drugs or drug paraphernalia will be turned over to an appropriate law enforcement agency and may result in criminal prosecution.

Required Testing

Pre-employment

Applicants being considered for hire must pass a drug test before beginning work or receiving an offer of employment. Refusal to submit to testing will result in disqualification of further employment consideration.

Reasonable suspicion

Employees are subject to testing based on, but not limited to, observations of apparent workplace use, possession or impairment by at least two members of management. HR and the Clinical Director or should be consulted before sending an employee for testing. Management must use the reasonable suspicion observation checklist to document specific observations and behaviors that create a reasonable suspicion that an employee is under the influence of illegal drugs or alcohol. Examples include:

- Odors (smell of alcohol, body odor or urine).
- Movements (unsteady, fidgety, dizzy).

- Eyes (dilated, constricted or watery eyes, or involuntary eye movements).
- Face (flushed, sweating, confused or blank look).
- Speech (slurred, slow, distracted mid-thought, inability to verbalize thoughts).
- Emotions (argumentative, agitated, irritable, drowsy).
- Actions (yawning, twitching).
- Inactions (sleeping, unconscious, no reaction to questions).

When reasonable suspicion testing is warranted, both management and HR will meet with the employee to explain the observations and the requirement to undergo a drug and/or alcohol test within two hours. Refusal by an employee will be treated as a positive drug test result and will result in immediate termination of employment.

Under no circumstances will the employee be allowed to drive himself or herself to the testing facility. A member of management must transport the employee or arrange for a cab, ride share (Uber, Lift, etc) and arrange for the employee to be transported home.

Post-accident

Employees are subject to testing when they cause or contribute to accidents that seriously damage a ACR Health Services vehicle, machinery, equipment or property or that result in an injury to themselves or another employee requiring offsite medical attention. A circumstance that constitutes probable belief will be presumed to arise in any instance involving a work-related accident or injury in which an employee who was operating a motorized vehicle (including a ACR Health Services van, pickup truck, or automobile) is found to be responsible for causing the accident. In any of these instances, the investigation and subsequent testing must take place within two hours following the accident, if not sooner. Refusal by an employee will be treated as a positive test result and will result in immediate termination of employment

Under no circumstances will the employee be allowed to drive himself or herself to the testing facility. A member of management must transport the employee or arrange for a cab, ride share (Uber, Lift, etc) and arrange for the employee to be transported home.

Random Testing:

ACR Health Services may elect in the future to put into effect random drug testing procedures. If that decision is made employees will be given 6-month notice before any random drug testing procedure will be put into operation and ACR Policy on Employee Random Drug Testing will be followed.

Collection and Testing Procedures

Employees subject to alcohol testing will be transported to a ACR Health Services-designated facility and directed to provide breath specimens. Breath specimens will be tested by trained technicians using federally approved breath alcohol testing devices capable of producing printed results that identify the employee. If an employee's breath alcohol concentration is .04 or more, a second breath specimen will be tested approximately 20 minutes later. The results of the second test will be determinative. Alcohol tests may, however, be a breath, blood or saliva test, at the company's discretion. For purposes of this policy, test results generated by law enforcement or medical providers may be considered by the company as work rule violations.

Applicants and employees subject to drug testing will be transported to a ACR Health Services-designated testing facility and directed to provide urine specimens. Applicants and employees may provide specimens in private unless they appear to be submitting altered, adulterated or substitute specimens. Collected specimens will be sent to a federally certified laboratory and tested for evidence of marijuana, cocaine, opiates, amphetamines, PCP, benzodiazepines, methadone, methaqualone and propoxyphene use. (Where indicated, specimens may be tested for other illegal drugs.) The laboratory will screen all specimens and confirm all positive screens. There must be a chain of custody from the time specimens are collected through testing and storage.

The laboratory will transmit all positive drug test results to a medical review officer (MRO) retained by ACR Health Services, who will offer individuals with positive results a reasonable opportunity to rebut or explain the results. Individuals with positive test results may also ask the MRO to have their split specimen sent to another federally certified laboratory to be tested at the applicant's or employee's own expense. Such requests must be made within 72 hours of notice of test results. If the second facility fails to find any evidence of drug use in the split specimen, the employee or applicant will be treated as passing the test. In no event should a positive test result be communicated to ACR Health Services until such time that the MRO has confirmed the test to be positive.

Consequences

Applicants who refuse to cooperate in a drug test or who test positive will not be hired and will not be allowed to reapply/retest in the future.

Employees who refuse to cooperate in required tests or who use, possess, buy, sell, manufacture or dispense an illegal drug in violation of this policy will be terminated. If the employee refuses to be tested, yet the company believes he or she is impaired, under no circumstances will the employee be allowed to drive himself or herself home.

Employees who test positive, or otherwise violate this policy, will be subject to discipline, up to and including termination. Depending on the circumstances, the employee's work history/record and any state law requirements, ACR Health Services may offer an employee who violates this policy or tests positive the opportunity to return to work on a last-chance basis pursuant to mutually agreeable terms, which could include follow-up drug testing at times and frequencies determined by ACR Health Services for a minimum of one year but not more than two years as well as a waiver of the right to contest any termination resulting from a subsequent positive test. If the employee either does not complete the rehabilitation program or tests positive after completing the rehabilitation program, the employee will be immediately discharged from employment.

Employees will be paid for time spent in alcohol or drug testing and then suspended pending the results of the drug or alcohol test. After the results of the test are received, a date and time will be scheduled to discuss the results of the test; this meeting will include a member of management, a union representative (if requested), and HR. Should the results prove to be negative, the employee will receive back pay for the times/days of suspension.

Confidentiality

Information and records relating to positive test results, drug and alcohol dependencies, and legitimate medical explanations provided to the MRO will be kept confidential to the extent required by law and maintained in secure files separate from normal personnel files. Such records and information may be disclosed among managers and supervisors on a need-to-know basis and may also be disclosed when relevant to a grievance, charge, claim or other legal proceeding initiated by or on behalf of an employee or applicant.

Inspections

ACR Health Services reserves the right to inspect all portions of its premises for drugs, alcohol or other contraband; affected employees may have union representation involved in this process. All employees, contract employees and visitors may be asked to cooperate in inspections of their persons, work areas and property that might conceal a drug, alcohol or other contraband. Employees who possess such contraband or refuse to cooperate in such inspections are subject to appropriate discipline, up to and including discharge.

Crimes Involving Drugs

ACR Health Services prohibits all employees, including employees performing work under government contracts, from manufacturing, distributing, dispensing, possessing

or using an illegal drug in or on company premises or while conducting company business. ACR Health Services employees are also prohibited from misusing legally prescribed or over-the-counter (OTC) drugs. Law enforcement personnel may be notified, as appropriate, when criminal activity is suspected.

ACR Health Services does not desire to intrude into the private lives of its employees but recognizes that employees' off-the-job involvement with drugs and alcohol may have an impact on the workplace. Therefore, ACR Health Services reserves the right to take appropriate disciplinary action for drug use, sale or distribution while off company premises. All employees who are convicted of, plead guilty to or are sentenced for a crime involving an illegal drug are required to report the conviction, plea or sentence to HR within five days. Failure to comply will result in automatic discharge. Cooperation in complying may result in suspension without pay to allow management to review the nature of the charges and the employee's past record with ACR Health Services.

Definitions

"Company premises" includes all buildings, offices, facilities, grounds, parking lots, lockers, places and vehicles owned, leased or managed by ACR Health Services or any site on which the company is conducting business.

"Illegal drug" means a substance whose use or possession is controlled by federal law but that is not being used or possessed under the supervision of a licensed health care professional. (Controlled substances are listed in Schedules I-V of 21 C.F.R. Part 1308.)

"Refuse to cooperate" means to obstruct the collection or testing process; to submit an altered, adulterated or substitute sample; to fail to show up for a scheduled test; to refuse to complete the requested drug testing forms; or to fail to promptly provide specimen(s) for testing when directed to do so, without a valid medical basis for the failure. Employees who leave the scene of an accident without justifiable explanation prior to submission to drug and alcohol testing will also be considered to have refused to cooperate and will automatically be subject to discharge.

"Under the influence of alcohol" means an alcohol concentration equal to or greater than .04, or actions, appearance, speech or bodily odors that reasonably cause a supervisor to conclude that an employee is impaired because of alcohol use.

"Under the influence of drugs" means a confirmed positive test result for illegal drug use per this policy. In addition, it means the misuse of legal drugs (prescription and possibly OTC) when there is not a valid prescription from a physician for the lawful use of a drug in the course of medical treatment (containers must include the patient's name, the name of the substance, quantity/amount to be taken and the period of authorization).

Enforcement

The HR director is responsible for policy interpretation, administration and enforcement.

Policy 10.29 – Employee Random Testing Drug-Testing Policy

Purpose

This policy describes ACR Health Services' procedures for conducting random drug testing of employees in its efforts to maintain a safe and drug-free workplace.

Random Selection

ACR Health Services will randomly drug-test employees for compliance with its drug-free workplace policy on a quarterly basis. Random testing means employees will be selected for testing using a computer-based random-number generator. This will result in an equal probability that any employee from the entire group of employees will be tested.

Each quarter, on a day selected by a computer-based random-date generator, the human resources department will pull a random selection of employee names and immediately notify the employees selected for testing. Testing must be completed on the same workday the employee is selected, absent extenuating circumstances such as out-of-town travel. In all circumstances, testing must be completed within 24 hours of selection.

If an employee selected for testing is unavailable for a legitimate reason such as an extended medical absence, human resources will document the circumstances for failure to test.

ACR Health Services has no discretion to waive the selection of an employee selected at random.

Substances Covered by Drug and Alcohol Testing

Employees will be tested for their use of commonly abused controlled substances, which include amphetamines, barbiturates, benzodiazepines, opiates, cannabinoids, cocaine, methadone, methaqualone, phencyclidine (PCP), propoxyphene and chemical derivatives of these substances.

Employees must advise the testing lab of all prescription drugs taken in the past month before the test and must be prepared to show proof of such prescriptions upon request.

Testing Methods and Procedures

All testing will be conducted by a licensed independent medical laboratory, which will follow testing standards established by the state or federal government. Testing will be

conducted on a urine sample provided by the employee to the testing laboratory under procedures established by the laboratory to ensure the privacy of the employee, while also protecting against tampering with or alteration of the test results.

Employees will be considered to be engaged at work during the time spent taking a drug test and will be compensated for such time at their regular rate of pay, with the exception of retesting at the request of the employee.

ACR Health Services will pay for the cost of the initial testing, including the confirmation of any positive test result by gas chromatography. The testing lab will retain samples in accordance with state law, so that an employee may request a retest of the sample at his or her own expense if the employee disagrees with the test result.

Refusal to Test

Employees who refuse to submit to a test or who adulterate, dilute or otherwise tamper with a test specimen will be subject to immediate discharge.

Consequences of Positive Test Results

If an employee tests positive on an initial screening test, the employee will be temporarily suspended while the confirmation test is being conducted.

A positive test result confirmed by a medical review officer of the laboratory will result in disciplinary action, up to and including discharge. Discipline selected by ACR Health Services will depend on a variety of factors, including the prior work record of the employee, the length of employment, the prior accident and attendance record of the employee, the circumstances that led to the testing, and proposals by the employee to address the problem.

All employees have the right to discuss their test results with testing laboratory personnel and ACR Health Services. These discussions should be considered confidential except that information disclosed will be communicated to personnel within ACR Health Services or within the laboratory who need to know such information to make proper decisions regarding the test results or regarding the employment of the individual.

Recordkeeping

All records concerning test results will be kept by ACR Health Services in medical files that are maintained separately from employee personnel files. Employees have a right to obtain copies of all test results from the testing laboratory or from ACR Health Services.

Retesting

Employees may request a retest of their positive test results within five working days after notification of a positive test result. This retest is at the expense of the individual, unless the original test result is called into question by the retest.

Where the employee believes that the positive test result was affected by taking lawful or prescribed substances not in violation of company policy, the employee may be suspended without pay pending substantiation of the employee's claims. Employees will be provided no more than five business days in which to produce this additional information.

11.01 - INFORMATION TECHNOLOGY POLICIES AND PROCEDURE MANUAL

11.01.1- TECHNOLOGY OVERVIEW:

POLICY: It is the policy of **Assertive Community Recovery, LLC d/b/a ACR Health Services** to inform and train all users regarding the acceptable use of technology equipment, information, responsibilities, and security. Initial and ongoing related training and competencies will be documented. The main objectives for acceptable use ensure:

1. The **confidentiality and security** of data and information are protected against unauthorized misuse or disclosure (or that prompt reporting occurs).
2. The **integrity** of data and information to protect from unauthorized or accidental modification.
3. The **availability and accessibility** of technology balanced against the need for use.

INTENT: The use of technology is meant to enhance services for persons served, personnel, and other stakeholders so that we can implement our mission.

GENERAL INFORMATION: The following information is to be used as an outline of what is expected regarding information technology (IT). It defines terms, identifies standards, and supports IT implementation. The policies and procedures for IT use will address the following topics:

a. **Acceptable Use of Technology and/or Equipment** which may include business computers, tablets, cell phones, USB drives, email, and internet, Wi-Fi, network access, Information and Communication Technology (ICT) for service delivery, or use of other applications.
    1. The acceptable use of all technology is implemented to support business processes, therapeutic service deliver, and **information systems** including how information is collected, processed, stored, and communicated.
    2. Guidelines for using the internet, Wi-Fi, and/or the network as well as other resources are specified regarding business computers, laptops, phones, tablets, and/or personal devices.
    3. The control and use of technology including bringing or using **personal devices** on the business network or for business purposes will also be addressed.
    4. See separate policy and procedures for, *Remote Service Delivery Using Information & Communication Technologies*

b. **Backup and Recovery Practices** refers to backing up data and the setting up of systems that allow data recovery. Additionally, the type of back up method used (on-site or off-site device or system) will be identified and evaluated. Regular monitoring and testing of the backup processes will be performed to verify they function as expected. Data retention timeframes, copies of data, as well as distribution of data will be addressed in backup and recovery planning.
    1. This policy and procedure will set rules and regulations for the backup and secure storage of all critical data and electronic information in the case of system damage/failure or other events such as natural disasters, data corruption, faulty data entry, espionage, or operation errors.
    2. It will also address technology utilized for areas like payroll, billing, scheduling, electronic health/medical records, financial collection methods, as well as other portable devices that may be used for data transfer.
c. **Business Continuity and Disaster Recovery** is used to help the business recover from a disaster, accident, or emergency, and continue operations.
    1. **Business continuity** will address the availability of essential business functions and may include replacing personnel, service availability issues, business impact analysis otherwise known as a BIA. Ready.Gov (www.ready.gov/business) has additional resources for completing a BIA.
    2. **Disaster recovery** processes may include server and network repair, replicating backup data, and supplying backup systems.
d. **Security** awareness seeks to educate users about the consequences of their actions regarding security and privacy. The policy and procedures for security address:
    1. **Access management** refers to initial access to IT systems, information access, user ID'/Passwords as well as the password policy.
    2. **Audit capability** refers to the record or audit log showing who has accessed a computer system and what operations have been performed during a given time frame.
    3. **Data export or transfer capabilities** will address what data is proprietary and secure as well as how or if data may be exported or transferred back and forth from business to personal device and from personal to business device.
    4. **Decommissioned hardware and data destruction** refer to the removal of active hardware to inactive status and how the hardware will be disposed of without risking access to the data that was stored on it.
    5. **Malicious activity protection** includes security features such as firewalls, spam filtering, and other systems designed to prevent abuse or unauthorized use.
    6. **Remote access** will define our standards for connecting the business network to any internal and/or external host (i.e., someone off site, a telecommuter, and/or someone traveling). These standards are created to identify what equipment can be used to perform company business and what kind of access is allowed.
    7. **Configuration management/updates** follow the hardware, software, or other related technology to track versions and updates installed on computer systems and network addresses belonging to hardware devices used.

8. **Change control** is meant to ensure that all changes made are managed, verified, approved, and tracked i.e., new technology, software updates, operating system updates, and firmware updates. Testing and analyzing these areas will help the business to understand the impact of the changes and ensure a smooth and orderly transition.

SCOPE: The policies and procedures apply to all business systems and those working at or for our organization including personnel, contractors or sub-contractors, or services purchased or contracted. Additionally, all vendors must meet the security and privacy rules to be utilized.

ORIENTATION: All new staff and other stakeholders, as appropriate, will be provided an Orientation or Onboarding Session regarding the various IT systems and practices.

1. New staff must read and acknowledge the "Acceptable Use of Information Technology" located within the ACR Policy and Procedure manual.
2. Staff must confirm they have read and agree by signing and dating the New Employee Orientation Form.
3. All training and competencies will be documented and filed in their personnel file or stored in our cloud-based system.
4. Various introductory activities include:
    - Being assigned Log On information and gaining access to the Internet, Network, as well as our (Wi-Fi).
    - Using their Network Username and Password to log into their workstation equipment.
    - Microsoft Outlook/Web Mail and the Cloud System.
    - Printing, Faxing, Calls, or mobile device.
    - Accessing various websites, software, and hardware specific to their position.
    - Technology Security such as Ransomware, Cybersecurity, and other current technology practices via completing Training online via *Accreditation Now, Inc*.
    - The Physical Environment regarding IT safety and security practices.
    - As applicable to the staff position, utilization of ICT in service delivery.

INFORMATION COLLECTION: Maintaining the security and integrity of collected information is crucial to our business viability. Administrative and clinical information is collected in a legal, ethical, and uniform manner per the guidelines and timeframes identified in relevant policies and procedures (refer to individual policies guiding each of these functions). Information is reviewed and analyzed for use in our strategic planning, various decision-making events, and quality improvement, Information is collected in accordance with our mission, vision, values, and program goals. Overall, the data collected is meant to:

1. Enhance quality clinical care and identify unmet needs.
2. Improve efficient business functions (health and safety, workforce management, strategic planning, risk management, performance improvement, etc.).
3. Increase productivity and foster effective communication among all stakeholders.

TECHNOLOGY DEMONSTRATION: The use of information technology services will be demonstrated in the following ways:

1. **The Website:** Stakeholders can become familiar with services, staff, beliefs, common misconceptions, scheduling, payments, job openings, surveys to determine quality of services or corporate compliancy, appointment requests, and online assessments with resources for accessing special accommodation requests, if needed.
2. **Hardware and Software:** The telephone systems, training software, intrapersonal file sharing, email, business accounting software, file management, billing software, electronic health record, payroll services, ICT delivery of services, online assessments, insurance, fee collection systems, and other technology services required by contracts or based on need.
3. **PR Material:** Newsletters, social media, and other electronic media will be used for marketing.

INFORMATION DISSEMINATION: Technology information will be disseminated to staff, persons served, and other stakeholders as appropriate and in accordance with individual policies. The above types of demonstration will be performed based on the type of input, outcome, and audience.

TELEHEALTH SERVICES: Telehealth services will be provided in accordance with ACR Policy 11.03 – Remote Service Delivery Using Information & Communication Technologies

RESPONSIBILITY: The CEO/Executive Director and Director of Quality Assurance and Compliance are responsible for coordinating the security and privacy of protected health information, the assessment and planning of technology needs, as well as ensuring appropriate training.

11.01.2 - ACCEPTABLE USE OF TECHNOLOGY

GENERAL USE AND OWNERSHIP: Proprietary information stored on electronic and computing devices whether owned or leased, remains the sole property of the business. Personnel must ensure through legal or technical means that proprietary information is protected in accordance with the data protection standard.

HARDWARE:

POLICY: Personnel are responsible for the technology resources entrusted to them. Due diligence and care should be exercised to ensure the security and integrity of these business resources including, but not limited to computers, monitors, modems, hard drives, keyboards, cell phones, mobile devices, tablets, mice, printers, and scanners.

PROCEDURE: Reasonable and prudent steps should be taken to protect agency-provided technology equipment or resources. At no time should safety toward hardware be compromised or circumvented.

1. Agency-provided hardware and other information systems should only be used as authorized by executive management.
2. Requesting, purchasing, or obtaining hardware must be approved by the appropriate staff member and follow the purchasing policy.
3. Use of agency-provided technology should conform to an individual's job function and/or specific job description.
4. Any action which breaches, evades, or circumvents reasonable and prudent methods of hardware use; should be immediately reported to the appropriate management.
5. Failure to report these actions is a violation of policy and subject to disciplinary action.

COMPUTERS: Company owned computers are for business use only. The use of personal electronic devices i.e., smart phone, tablet, desktop computers, or laptops is **prohibited** for business use, unless authorized by the Executive Team or designee.

1. Security verification will be performed on the device to ensure the security of the device.
2. All computers must be password protected and only those persons who are authorized can use or have access to approved devices.
3. Each person authorized is assigned a security code or password and must sign a confidentiality statement. Security codes or passwords shall be changed periodically, and information must be backed up regularly.
4. If you are using a personally owned device for company, use, the device must have appropriate security software installed and meet minimum requirements for

maintaining security. This verification will have to be performed by management and documented.

5. The desktop or laptop requirements include meeting certain performance requirements such as, but not limited to:
    a. Screen Size*: 12-inch minimum screen size).*
    b. Monitor resolution: 1024 x 768 minimum
    c. Keyboard and mouse: will be a wired device.
    d. Will include: speaker, microphone and webcam.
    e. The minimum capacity of the computer size: 1 GHZ or faster x86 or 64-bit processor with SSE2 instruction set
    f. Minimum memory: 16-GB RAM (32-bit)
    g. Internal Hard Drive Storage: 512-GB
    h. USB Ports (4 USB ports).
    i. 10/100/1000 Ethernet Port

PORTABLE DEVICES: The purchase of portable devices such as cell phones, tablets, and laptop computers must meet the guidelines for purchasing equipment under the financial policy.

1. Portable systems must run Windows 10 or higher Operating System and integrate with existing hardware.
2. The minimum capacity of the portable system must be:
    a. Display: 12.3" 2400x1600
    b. Processor Speed 2.2Ghz minimum
    c. 4GB RAM Memory (on BD 4GB)
    d. Hard Drive: 32GB).
    e. 2 USB ports).
    f. Microphone port, webcam, speakers
3. The portable system must be able to run the following applications/software:
    a. Internet Browser: Google Chrome, Firefox, Safari/iOS.
    b. Most current version of Microsoft and Office 365.
    c. Cloud Storage Microsoft SharePoint/One Drive.
    d. Security: Anti-Malware: Bit Defender or Malwarebytes.
    e. Adobe Acrobat, JAVA, Brother Printing/Scanning.
    f. QuickBooks, ShareNote Electronic Medical Records

EXTERNAL DEVICES: This may include modem, routers, monitors, keyboards, mice, printers, scanners, fax machines, projectors, phones, shredder, mailing equipment, and other security devices.

1. Purchase and use of all other computer peripherals can only be authorized by CEO.
2. External devices must be compatible with the company's current hardware and software systems.
3. Mobile device(s) must be purchased through an authorized retailer.
4. The request for accessories (hands free kit, additional scanner, label maker/printer, etc.) must be included with initial request for purchase.
5. All purchases of devices must be supported by 1–2-year manufacturer warranty or other guarantee.

BRING YOUR OWN DEVICE: This policy provides guidelines for the use of personally owned laptops, notebooks, smart phones and tablets for business purposes. All staff who use or access our business technology equipment and/or services are bound by the conditions of this policy.

1. Staff must register their device for business use and report what applications that are being used for business purposes on personal devices.
2. Staff will register their devices when completing their onboarding and/or orientation to the Technology Standards. The following can be used for business purposes:
    a. Approved device for the use for email access using appropriate security measures.
    b. Approved device for the use of business internet access using appropriate security measures.
    c. Approved device for the use of business telephone calls (VOIP) using appropriate security measures.
    d. Approved use of the Electronic Medical Record using the appropriate security measures.
3. All staff who have registered personal devices for business use acknowledge that the business:
    a. Owns all intellectual property created on the device.
    b. Can access all data held on the device.
    c. Will regularly backup the data held on the device.
    d. Will delete all data held on the device in the event of loss or theft.
    e. Has the first right to buy the device if the staff member wants to sell.
    f. Will delete all data held on the device upon termination of the staff member.
    g. Has the right to deregister the device for business use at any time.
4. Each staff member that utilizes personal devices agrees:
    a. Not to download or transfer business or sensitive information to the device. Sensitive information includes business or personal information sensitive to the business such as intellectual property, personnel details, client information, etc.
    b. To maintain the device with current operative and security software.
    c. Not to share the device with other individuals to protect the business data access through the device.
    d. To abide by the internet policy for appropriate use and access of the internet.
    e. To notify the business immediately in the event of loss or theft of the registered device.
    f. Not to connect USB memory sticks from an untrusted or unknown source to equipment.
5. To keep devices secure, the following must be observed:
    a. Devices must never be left unattended in a public place, or in an unlocked home, vehicle, or even if it locked. Wherever possible, staff should keep device on their person or securely locked away.
    b. Devices should be carried on as hand luggage when traveling.
    c. Passwords and encryption should always be utilized for device access.

SOFTWARE:

POLICY: Staff may be required to use a company owned computer to complete the responsibilities of their position. The CEO/Executive Director is the only person authorized to approve software use, changes, or purchases.

INTENT: Ensure that all software used is appropriate, has suitable value regarding cost vs. need, and integrates with other used technology.

OVERVIEW: There are typically three classifications of software. This includes Systems Software which aids the user and the hardware to function and interact with each other, Programming Software, as well as Application Software. Unauthorized software applications may be removed as all software needs to be approved and evaluated on an individual basis and implemented using the appropriate configuration procedure.

APPROVED SOFTWARE: The following is a list of software programs that are authorized to be on Business Computers *(Select the programs below currently in use, delete unused software, and add any missing programs to the list):*

- Operating Systems like MS Windows, Macintosh Operating System, iOS, or Android.
- Device Drivers such as Printer Drivers, USB Drivers, Display Drivers, VGA Drivers, Keyboard/Mouse Drivers, or other Virtual Devices.
- Licensed Microsoft Office Suite, OpenOffice.org or Outlook.
- Java and Adobe Acrobat Reader.
- Internet Web Browsers like Microsoft Edge, Internet Explorer, Mozilla Firefox, Safari, or Chrome.
- Anti-Virus, Malware Software, or Firewall Protection: BitDefender
- Bookkeeping systems: QuickBooks.
- Practice Management and Electronic Health Record: ShareNote or a future system as designated and approved by CEO.
- Internet Phone/VOIP Operating System: Intermedia.
- Secure Email Systems: Microsoft 365, CPanel Webmail.
- Telehealth Video Conferencing Systems: MS Team,Zoom, Doxy.Me, Google Duo.
- Cloud Systems such: MS Share Point, One Drive.
- Document Collaboration: Microsoft 365 Teams.
- Form Development and Electronic Signature Software: LuxSci SecureForm, DocuSign.
- Note Taking Software or Note taking Devices with Apps: Notability, Livescribe Smart Pen by Anoto.
- E-Prescribing Software: DoseSpot.

PROCEDURE: Reasonable and prudent steps should be taken to protect agency-provided technology equipment and resources. At no time should safety toward software be compromised or circumvented. Software procedures are outlined below:

1. ACR Health Services provided software and other information systems should only be used as authorized by executive management.

2. Requesting, purchasing, or obtaining software must be approved by the CEO and follow the purchasing policy prior to the use or download of such software.
3. All software that is purchased must be sold by authorized software sellers and meet relevant security rules so that configuration can be implemented smoothly.
4. All purchased software must be supported and compatible with the operating system identified below.
5. Any changes from the requirements must be authorized by the CEO.
6. Use of ACR Health Services provided technology should conform to an individual's job function and/or description.
7. Any action which breaches, evades, or circumvents reasonable and prudent methods of software use; should be immediately reported to the management.
8. Failure to report these actions is a violation of policy and subject to disciplinary action.

SOFTWARE USAGE: All personnel must receive training relevant to their job description and use prior to the use of any software. This will be the responsibility of the appropriate management team member. Staff is prohibited from bringing software from home and loading it onto company hardware.

1. Unless express approval is obtained from CEO, software cannot be taken home and loaded on personal devices.
2. When a staff member is authorized to take home a company device, the use of all software or hardware must be business related unless previously approved.
3. Illegal use, reproduction, or duplication is strictly forbidden and may be subject to civil and criminal penalties including fines and imprisonment.

SOFTWARE AUDIT: There will be periodic audits of all company owned PC's, including laptops to insure we follow software licenses. Audits will be conducted using BitDefender and Microsoft 365 Security & Compliance Center.

1. Software for which there is no supporting registration, license, and/or original installation will be removed from the user's computer.
2. A search for viruses and any other unknown software will also be implemented.
3. Full cooperation of all users is required.
4. The company reserves the right to audit networks and systems on a periodic basis to ensure compliance with acceptable use policy.

BROWSER AND OPERATING SYSTEM (OS) BEST PRACTICES: To guarantee the best experience, get the most out of our electronic systems, and ensure security and performance, the following best practices are to be applied:

1. Keep your OS and browser updated.
2. Enable JavaScript and cookies.
3. Utilize AdBlock and other security protections.
4. Disable Autofill.
5. Remove browser extensions.

OPERATING SYSTEM OVERVIEW: The Operating System (OS) has 3 basic functions: (1) managing the computer's resources like the central processing unit, memory, disk drives, and

printers, (2) establishing a user interface, and (3) executing and providing services for software applications. To keep the browser working smoothly, it is best to make sure the OS is up to date and current with business standards. System updates can fix performance issues for the browser, internet connection, and other key features. To update the OS, use the following links:

1. Operating System-Mac OS
2. Operating System-Windows

BROWSER: Your browser is the program used to navigate the World Wide Web. Each browser update comes with improvements, installs new features, and fixes performance issues that keep your browser running smoothly, safely, and error-free. The minimum requirements for successfully using our software technology include:

1. A reliable internet connection with a bandwidth of at least 10 mbps which will minimize connection issues and provide the best quality interactions.
2. Newer devices purchased in the last 3-5 years.
3. A computer that has at least 2.5 GHz processor and 4 GB or more of RAM.
4. For Apple Computers the latest version is recommended.
5. For Windows Computers: Windows 10 or higher.
6. Web Browsers such as Google Chrome version 71, Mozilla Firefox version 64, and Apple Safari version 12.
7. For Mobile devices (iOS or Android) use at least iOS 12 or newer.

INTERNET: The following guidelines are for accessing and utilizing the internet through the company's network. Internet services are authorized to staff based on their job description and to enhance services provided. The internet is a great tool but comes with security implications we must guard against. For that reason, staff are granted access only as a means of providing support when fulfilling their job responsibilities.

1. Internet accounts are approved for designated staff members by their supervising manager.
2. Each person is responsible for the account issued to them as well as ensuring the security of their issued accounts.
3. Sharing of one's User Id or Password is prohibited.
4. Use of the internet must reflect the business mission and support company goals and objectives for providing services.
5. No staff member may use the business' internet to deliberately propagate any virus, worm, trojan horse, or other malicious malware.
6. The following constitutes inappropriate use of the internet and is not permitted:
    a. Accessing, uploading, downloading or distributing pornographic or sexually explicit material
    b. Violating state, local, or federal laws.
    c. Vandalizing or damaging the property of any other individual or of the company.
    d. Invading or abusing the privacy or rights of others.
    e. Violating copyright or using intellectual property without permission.
    f. Using the network for financial or commercial gain.
    g. Degrading or disrupting the network performance.

EMAIL: The use of email must be consistent with Company policies and procedures for ethical conduct, safety, and in compliance with applicable laws and proper business practices. The Company email account should be used primarily for business related purposes. Personal communication is permitted on a limited basis, but nonrelated commercial uses are prohibited.

1. All data contained within an email message or attachment must follow the secure data transfer protection standards *(listed near the end of this document).*
2. Personnel must use extreme caution when opening e-mail attachments received from unknown senders, which may cause malware.
3. Email messages should be retained if they qualify as a business record. Email messages are considered a business record if there is a legitimate and ongoing reason to preserve the information contained in the message.
4. The email system shall not be used for the creation or distribution of any unacceptable usage including disruptive messages, offensive comments about race, gender, hair color, disabilities, age, sexual orientation, pornography, religious beliefs and practices, political beliefs, or nation origin. Personnel who receive any emails with this content form other staff members should report the matter to their supervisor immediately and utilize the grievance reporting system, if warranted.
5. Users are prohibited from automatically forwarding business email to personal accounts or 3rd party email systems. Individual messages which are forwarded by the user must not contain any confidential or private information.
6. Personnel is prohibited from using 3rd party email systems and storage servers such as Google, Yahoo, and MSN Hotmail, etc. to conduct business, to create transactions, or to store/retain information.
7. Personnel shall have no expectation of privacy in anything they store, send, or receive on the company's email system.
8. Email accounts and messages may be monitored without prior notice or warning.

See ACR Policy 11.04 - Internet, E-Mail, and Computer Use Policy

11.01.3 - BACKUP PRACTICES\

POLICY: All business-critical data will be backed up daily using Office 365 One Drive to protect and ensure data integrity. An offsite data storage facility, backup hard drives, and other cloud-based systems will be utilized to ensure business continuity.

INTENT: Ensure continuity of services through regular backup of all technology and data. This provides the assurance that the use of systems will be available and ensures the safe and effective storage of critical information. Additionally, our intent is to minimize risk by implementing a set of processes to recover from a disaster and continue or resume business.

PROCEDURE: The organization is responsible for the backup of data held in **central systems** and related databases. The responsibility for backing up data held on the workstations of individuals regardless of whether they are owned privately or by the organization falls entirely on the user. In the event of a disaster, daily backups would restore all applications and information. Once the restore is complete, full access will be available.

The procedures below are used to ensure backups between servers occurs so that if one server becomes unavailable, access is available through another avenue or separate location until a full restoration is complete.

1. The staff/contractor/vendors shall have backup servers that will back up nightly with recovery software that is built into the approved operating system or programs.
2. Network data and programs are backed up daily and archived off site in the case of emergency, this is to minimize risk in the following disasters:
    a. Critical computer systems.
    b. User vulnerability and/or user area vulnerability.
    c. Loss of building, loss of key staff, loss of IT Network, loss of power.
    d. Weather related incident.
    e. Security issue.
    f. Software or Hardware failure.
    g. Virus or other Security breach.
    h. Website Disruption.
3. Data and software on your PC may not be backed up. If you want to protect data and files used on your PC, the following measures should be taken:
    a. Save the data onto the Cloud System-Dropbox, EMR, or relevant program.
    b. Copy the data to the appropriate network server and store it within your personal file folder specifically set up for this purpose. This will ensure the important data is saved and archived in the daily backup process.

4. Backups of data must be handled with the same security precautions as the data itself. When systems are disposed of, or re-purposed, data must be certified or deleted, or disks destroyed consistent with industry best practices for the security level of the date.
5. To validate the backup can be created completed within a timely basis, a test database is verified using the daily backups.
6. Some backups may be stored using backup hard drives which will follow security storage rules and guidelines.
7. Ongoing assessment of Technology will be performed, and planning will occur annually. It will be updated as needed.

11.01.4 - BUSINESS CONTINUITY AND DISASTER RECOVERY

POLICY: The company is committed to ensuring that regular business services can be maintained in the event of a disaster (ranging from weather-related to catastrophic) using key technologies and disaster preparedness measures.

INTENT: Ensure we are better prepared in the event of a disaster by having basic technology services available or by utilizing a plan to support resuming business.

PROCEDURE: Since we utilize virtual services in a variety of ways, disaster preparedness methods will be maintained using key IT services employed through the following methods:

1. **Phone Systems**: In the event of a disaster rendering the phone systems unusable, cell phones will become the primary method of contact for key office personnel. A list of cell phone numbers and home phone numbers is maintained and updated regularly. Office calls will be forwarded to the appropriate person's phone to manage business calls.
2. **Internet Servers/Networks:** Alternative secure internet access could be established if the office server or network is down. A secure "Hotspot" could be implemented in the event of an office disaster. This will be used for essential services only, until the network is restored.
3. **Data Storage:** All data is backed up daily utilizing our secure cloud-based system and will be virtually restored when necessary.
4. **Remote Connectivity**: : If a disaster has prevented work from the administrative office; all critical operational data is stored in the cloud, therefore staff will be able to work remotely for any location that has internet and cell phone service.
5. **Equipment/Computers**: Additional laptops could be made available for personnel to work remotely from home following remote device guidelines. Necessary equipment would be transported overnight, configured and replaced.
6. **Security and privacy management:** All policies and procedures for security and privacy management are to be followed. If it is a security breach that has caused the disaster, appropriate risk measures (for reporting) will be taken according to the breach.
7. **Business Continuity Plan:** See ACR Policy 09.26 - Business Continuity Plan.
8. **Business Impact Analysis:** A Business Impact Analysis will be developed with the goal restore technology hardware, applications, and data in time to meet the needs of the individuals and families that participate ACR Health Services programs.

11.01.5 - SECURITY

POLICY: Reasonable and prudent steps should be taken to protect business data and information systems. At no time should these steps be breached, evaded, bypassed, or circumvented. Any action which breaches, evades, or circumvents these reasonable and prudent steps should be immediately reported to management. Failure to report these actions is a violation of policy and subject to disciplinary action.

INTENT: Every staff member or service contractor employed is responsible for the business resources entrusted to them. Due diligence and care should be exercised to ensure the security and integrity of all resources including safeguarding and protection of data and other IT systems.

PROCEDURE: Data and information systems should only be accessed according to one's respective job function and description. Approval and use must be authorized by Executive Staff and/or designated person. Threat prevention must be utilized to protect against negligent and/or intentional damage. Business continuity and recovery from this damage is imperative if the business is to operate without interruption.

1. **Security Overview:** ACR Health Services uses BitDefender provide to essential real-time protection for ACR computers against all viruses, ransomware, phishing and online fraud while browsing.
2. **Access Management:** Access to the network, servers, and other systems will require individual unique logins for authorization to the system. Authentication includes the use of passwords to gain access to the system.
    a. **Passwords:** System level and user level passwords must comply with ACR Policy 11.05 – Computer and Electronic Device Password and the password policy outlined below. Providing access to another individual, either deliberately or through failure to secure access, is prohibited. All computing devices must be secured with a password protected screensaver with the automatic activation feature set to 10 minutes or less. Personnel must lock the screen or log off when the device is unattended.
        - Passwords must consist of a minimum of eight (8) characters and must contain three of the four following attributes – upper-case letter, lower-case letter, number or symbol.
        - Passwords are not to be shared with anyone.
        - New passwords must be significantly different than the previous five used passwords.
        - When a staff member forgets their password or is locked out after 3 unsuccessful attempts, then the CEO will reissue a new initial password that will be required to be changed upon successful log in.

b. **Physical Access:** For all servers, mainframes and other network assets, the area must be secured with adequate ventilation and appropriate access through keypad lock. All devices must be securely locked in offices with appropriate password protection and/or encryption measures in place.
c. **Encryption:** Policies, procedures, scenarios and processes shall identify confidential information or PHI that must be encrypted to protect against persons or programs that have not been granted access. Apple offers built-in encryption for both mobile iOS and the desktop OS X systems, Microsoft Windows offers BitLocker, and Android also supports encryption out of the box.
d. **Technology Access:** Authorization of technology use will be performed upon new hire orientation/onboarding and completion of technology training relevant to one's job role. Deactivation or de-authorization will be implemented upon termination, security issue, or other policy breach.
e. **Audit Capabilities:** Audits will be performed of servers, firewalls, websites, log history, and other technology on a regular basis using McAfee Endpoint Security tasks. These reviews will include monitoring access logs, results of intrusion detection software, and web security. Vulnerability and risk assessment will be virtually conducted on a weekly or monthly basis depending on the type of audit and the results of the report. The program used for this is McAfee including anti-malware tools and encryption tools located at https://www.mcafee.com/enterprise/en-us/downloads/free-tools.html.

3. **Decommissioning of Physical Hardware and Data Destruction:** Technology equipment often contains elements which cannot be thrown away. Therefore, proper disposal of equipment is both environmentally responsible and usually required by law. In addition to hard drives, USB drives, CD-ROMs, and other storage media that may contain carious types of IT data, some of this data is sensitive. To protect our stakeholder's data, all storage mediums must be properly erased before being disposed of. Deleting or formatting data is insufficient because it can still be accessible until it is overwritten by a new file. Consequently, special tools shall be used to securely erase data prior to equipment decommissioning or destruction. Best practices for data destruction include:
    a. **Metadata Standard:** Metadata summarizes basic information about data which can make finding and working with specific data easier. For example, a clinical metadata standard may include a unique identifier that identifies the file type, the start of services, the type of services, the conclusion of services, as well as the legal destruction date
    b. **Records Retention Schedule**: The retention of health care records must follow HIPAA policies and procedures and documentation requirements which states that information must be retained for a minimum of 7 years from when the document was created or the date when it was in effect, whichever is later.
    c. **Destruction Processes:** Hard Drives will be removed from all devices before disposal. ACR contracts with Iron Mountain who will pick and take hard drives and devices where the hard drive cannot be removed to their facility where the hard drive/device will be shredded.

   d. **Destruction and Release Log:** The Quality Assurance Director will complete the Destruction and Release Log Form as well as ensuring a Certificate of Destruction has been received to verify compliance with relevant state and Federal rules, guidelines, and/or laws.

4. **Malicious Activity Protection:** BitDefender is the tool used for Virus Protection, Endpoint Security, Cloud Security, and as a Common DLP Engine. This is employed to ensure the integrity of all operating systems including Windows, macOS, Android, and iOS so that we can defend ourselves against viruses, malware, spyware, and ransomware attacks while staying on top of privacy and security.
   a. **Security Protection:** McAfee protects against security threats by utilizing anti-virus protection, protecting and shredding sensitive files, deleting cookies, safe web browsing, performance optimization, multi-device compatibility, encrypted storage, and more.
   b. **HIPAA rules** continue to apply with the use of personal computers including password protection as well as the use of anti-virus and firewall protection. Tablets, smartphones, or other mobile devices shall have Malware installed. All electronic devices must have up to date operating systems.
5. **Remote Access:** These policies are meant to provide guidelines for appropriate use of remote access capabilities to the company's network, business applications, and technology systems. This policy applies to all staff, contractors, vendors, and other agents with a company owned or personally owned device used to connect to the company network. Activities include reading or sending email, viewing intranet web resources, utilizing the electronic medical record, or any other applications used for business. The same type of security measures must be implemented for remote access.
      1. **Training:** Data security and client confidentiality procedures are an indispensable and integral part of the system policies and procedures therefore, training will occur for new staff, upon the use of new technology, and as needed or warranted. This will be performed by appropriate staff and with HIPAA compliance in place. Sources for training are:
         a. Accreditation Now, Inc. Technology Training
         b. U.S. Department of Health and Human Services (HHS)Technology Training Security Awareness and Training. *https://www.hhs.gov/about/agencies/asa/ocio/cybersecurity/security-awareness-training/index.html*

11.01.5 - HIPAA, PRIVACY, AND CONFIDENTIALITY:

POLICY: The business information systems, data, and technology assets, which include but are not limited to computers, computer networks, printers, and other related pieces of equipment and/or systems, are the property of the agency and are valuable company assets.

INTENT: Individuals using and having access to this technology must take reasonable and prudent steps to preserve the integrity of the systems, the data, and to protect the information. These assets are to be used for appropriate business-related functions only.

GENERAL INFORMATION: All communications made and transmitted within the agency shall be professional in nature as they represent the agency, our culture, and the individuals we serve. Prior to the use of the agency data and telecommunication systems, the staff member or company/individual hired by the agency is required to read the information policies and sign an acknowledgment statement.

Information and technology assets include but are not limited to the hardware, software, equipment that makes up workstations, local area networks, wide area networks, telephone, and other communication systems. All changes, modifications, and alterations to computing assets must be made and/or approved by the Executive Team.

PROCEDURE: Confidentiality of all treatment information and records shall be kept, recorded, released, maintained, and provided to requesting parties, in accordance with all applicable state and federal laws.

1. The “Minimum Necessary” rule is required of all personnel to ensure only the minimum protected health information necessary to carry out treatment, payment, and healthcare operations are released via any technological system. Refer to the policies concerning Confidentiality for additional information.
2. Reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure will be maintained by the following safeguards:
    a. Shredding documents containing PHI before discarding them.
    b. Securing clinical records with lock and key or pass code.
    c. Limiting access to keys or pass codes.
    d. Passwords are established through the Management Team.
    e. Sharing of passwords between staff members is forbidden.
    f. New or change of current password is available upon request.
    g. Personnel must set up their workstations to automatically log off after a predetermined time of inactivity, i.e., a screensaver with a password.
    h. Individually identifiable information shall not be transmitted via email.

i. A “Security Officer” will be designated by the agency director and will function as the security officer for safeguarding the records and billing data.
j. A “Privacy Officer” will be designated by the agency director to ensure compliance with all HIPAA requirements.

PHI STORAGE: When protected health information (PHI) is stored on any personal electronic device i.e., smart phone, tablet, laptop, flash drives or any other device capable of storing electronic information, the user must ensure the devices has a secure complex password. The company may issue encrypted flash drives for use or data can be saved in approved software-based cloud systems or other medical record systems.

11.1.6 - ASSISTIVE TECHNOLOGY

POLICY: The agency will attempt to provide appropriate assistive technology to staff and persons served with disabilities. We are committed to training staff on how to most effectively use assistive technology to improve quality services. Training is accomplished via in-person, one-on-one, group presentations, or on your own through work or home study.

INTENT: Multiple methods of assistance for staff, clients, and other stakeholders will be available upon reasonable request, ability to meet request, and options available. Cost will be a factor upon ability to meet need.

GENERAL INFORMATION: Assistive technology is defined as any item, piece of equipment, or product, whether acquired commercially, off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities.

PROCEDURE: The need for assistive technology must be determined on a case-by-case basis. Reasonable Accommodation Requests are to be made to the next level of management. The Executive Team or designated staff member has deciding vote on request. If it is determined that assistive technology item is required for personnel to be provided a reasonable opportunity to perform the responsibilities of job or to meet the needs of persons served, the technology will be provided.

Examples of assistive technology include:

- Customized office furniture or supplies.
- Specialized keyboard (ergonomic or large key).
- Voice recognition software.
- Large monitors.
- Video phones.
- Screen magnifiers.
- Optical character recognition (OCR) scanning software.

Additionally, other safety accommodations such as wide hallways/walkways, wheelchair ramps and strobe/vibrating alarm systems are common to all offices.

RIGHTS RESERVED BY THE BUSINESS: Violation of policy or misuse of business assets is subject to disciplinary action up to and including termination. Failure to report violations constitutes a violation in policy and is therefore subject to disciplinary action. These policies are intended to augment existing State, Federal, and copyright laws. Failure to comply with applicable State, Federal, or copyright laws is considered a violation in policy and may be subject to criminal prosecution. The agency reserves the right to monitor, audit, screen, and preserve data as the agency deems necessary in to maintain compliance with company policy.

11.1.7 - ELECTRONIC MEDICAL RECORDS:

POLICY: Provide a comprehensive set of resources designed to support the organization in areas critical to obtaining and maintaining accreditation and funding.

INTENT: Make use of supportive technology to run throughout all sections of the policy manual, including both the administrative and clinical sections, and to ensure a perpetual state of improvement.

PROCEDURE: Implement new and improved technology to maintain and improve our commitment to quality standards.

Personnel Acknowledgement Form:

1. You need to complete the security awareness training and agree to uphold the acceptable use policy.
2. If you identify an unknown, un-escorted or otherwise unauthorized individual in area storing medical records or systems logged on the EMR you need to immediately notify the Office Administrator or any ACR Director.
3. Visitors to must be escorted by an authorized employee at all times. If you are responsible for escorting visitors you must restrict them appropriate areas.
4. You are required not to reference the subject or content of sensitive or confidential data publicly, or via systems or communication channels not controlled by. For example, the use of external e-mail systems not hosted by ACR Health Services or any personal email accounts to distribute data is not allowed.
5. Please keep a clean desk. To maintain information security you need to ensure that all printed PHI data is not left unattended at your workstation.
6. You need to use a secure password on all systems as per the password policy. These credentials must be unique and must not be used on other external systems or services.
7. Terminated employees will be required to return all records, in any format, containing personal information. This requirement should be part of the employee onboarding process with employees signing documentation to confirm they will do this.
9. You must immediately notify in the event that a device containing PHI data is lost (e.g. mobiles, laptops, etc.).
10. In the event that you find a system or process which you suspect is not compliant with this policy or the objective of information security you have a duty to inform Director of Quality Assurance and Compliance so that they can take appropriate action.
11. If you have been assigned the ability to work remotely you must take extra precaution to ensure that data is appropriately handled. Seek guidance from your supervisor if you are unsure as to your responsibilities.

12. Please ensure that assets holding PHI data are not left unduly exposed, for example visible in the back seat of your car.
13. Data that must be moved within is to be transferred only via business provided secure transfer mechanisms (e.g. encrypted USB keys, file shares, email etc.). will provide you with systems or devices that fit this purpose. You must not use other mechanisms to handle PHI data. If you have a query regarding use of a transfer mechanism, or it does not meet your business purpose you must raise this with the Quality Assurance and Compliance Director.
14. Any information being transferred on a portable device (e.g. USB stick, laptop) must be encrypted in line with industry best practices and applicable law and regulations. If there is doubt regarding the requirements, seek guidance from Director of Quality Assurance and Compliance.

Policy 11.02 - Electronic Signature Policy and Procedure

A. Definition: Per HIPPA guideline 142.310 the electronic signature is defined as the attribute affixed to an electronic document to bind it to a particular entity. The electronic signature secures user authentication via password protected access at the time the signature is generated and creates the logical manifestation of user signature (multiple parties not allowed access or use) on a document or similar. Document supplies additional information such as signature purpose specific to the user; and ensures the integrity of the signed document to enable transportability of data, independent verifiability, and continuity of signature capability. Verifying a signature on a document verifies the integrity of the document and associated attributes and verifies the identity of the signer.

B. Policy

1. ***Please note the following Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)'s requirements for a Secure Electronic Signature, which may be found on page 388 of the April 1, 2022 Provider Manual for Community Behavioral Health Providers.***

   "As defined in PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS, a Secure Electronic Signature means an electronic or digital signature, symbol, or process associated with a document which is created, transmitted, received, or stored by electronic means which (1) requires the application of a security procedure; (2) capable of verification/authentication; (3) adopted by a party with the intent to be bound or to authenticate a record; (4) signed under penalty of perjury; (5) unique to the person using it; (6) under the sole control of the person using it; and (7) linked to data in such a manner that if the data is changed the electronic signature is invalidated."

   As further stated in the Provider Manual, page 376: ***All signatures (and initials, where appropriate) must be dated by the person signing or initialing to reflect the date on which the signature/initials occurred (e.g., no backdating, no postdating, etc.).***

2. It has been the long-standing policy of ACR Health Services that our agency will meet or exceed all compliance requirements and the directives of all regulatory/accreditation organizations. As a result, ACR Health Services will strictly adhere to the above DBHDD policy on electronic signatures. ACR will put in place measures and supervisory controls to enforce DBHDD electronic signature requirements.

3. Simply stated the date of the signature on all clinical documentation to include ShareNote Electronic Medical Record (EMR) Progress notes must be the date that the note was actually signed. Adjustments have been made to the ShareNote system that

prevents staff members from backdating or postdating progress notes. Staff members who continue to fail in completing clinical documentation in accordance DBHDD and ACR's Documentation Standards will be subject to corrective action plans to improve the staff member performance and ensure compliance with this directive. Continue failure to date clinical documentation correctly may result in termination.

C. Procedures:

1. The electronic signature is a "digital signature". A "digital signature" is an electronic signature based upon cryptographic methods of originator via password so that the identity of the signer and the integrity of the data can be verified or as provided in cloud-based systems to send documents and capture electronic signatures.
2. The electronic signature method used by ACR will ensure all of the following features:
    a. Documents with electronic signature maintain integrity via password protected access of electronic signature on user's computer. User's original signature will be electronically scanned into user's computer via protected PDF format.
    b. Since only the user has password protected access and use of the PDF electronic signature, the identity of the user signature on documents or similar entity, is sufficient to prove message integrity and prevent a third party from successfully denying the origin, submission, or delivery of the message and the integrity of its contents.
    c. Actual and electronic signature of user can be identified by any entity receiving a user document with electronic signature by verbal request in person, or otherwise, and/or electronic request. User will provide upon request.
    d. Public verification of user signature is available upon request.
    e. Independent verifiability of the user signature without the cooperation of the user (signer) is available by calling (404) 508-0078.
    f. Transporting of data via an electronically assigned document is accomplished in hard copy or electronically protected PDF format from user to third party. This maintains the integrity of the document and signature to the extent fraudulent tampering does not occur.

Policy 11.03 – Remote Service Delivery Using Information & Communication Technologies

I. POLICY:

A. ACR Health Services implements services to persons served using a variety of evidence-based strategies and practices. Based on the person's served individualized treatment plan, staff may utilize information\and, or communication technologies (ICT) for the delivery of services to the person served, family/support, and other providers located offsite or at remote settings.

B. It is the policy of ACR Health Services that programs and staff utilizing ICT conform to all organization and program policies and procedures for ICT service delivery, as well as legal and regulatory requirements, and accreditation standards. Service delivery using ICT will be included in the organization's ongoing assessment of technology (see relevant policies, planning documents, and procedures).

II. PROCEDURES:

A. **Positions Responsible for ICT Implementation**:
The Quality Assurance and Compliance Director is charged with the oversight of ICT service delivery for ACR Health Services. This role ensures:

1) Service delivery development and program implementation.
2) Policies, procedures, and practices are current.
3) Auditing for compliance to all legal and regulatory requirements.
4) Insurance requirements are met and or payment for these services is available.
5) Adherence to the programs standards of care and utilization of services, policy and procedures.

These responsibilities will be delegated as follows:

1. Clinical Director – Adult and C&A Core Programs:
2. ACT Team Leader
3. Housing Support Director
4. Specialty Program Director

B. Positions Utilizing ICT for Service Delivery:
The following positions may be reasonably expected to utilize ICT for service delivery:

1) Case Manager.
2) Psychologist.
3) Certified Peer Specialist (CPS)
4) Therapist.
5) S/A Therapist.
6) Physician/Nurse Practitioner.

7) Nurse.
8) Others as identified and approved by *Clinical Director*

C. Services Provided:

The following identifies the type of services that may be reasonably expected to be implemented using ICT:

1) Assessment
2) Individual Planning for Persons Served.
3) Monitoring.
4) Education and Prevention Strategies.
5) Interventions.
6) Follow-up.
7) Consultation.
8) Counseling.
9) Other services as identified and approved by Program Director or ACT Team Leader.

D. Service Implementation:

1) Written consent for ICT services will be obtained from the person served by the Program Director or ACT Team Leader, when applicable to service delivery utilizing ICT. The specific type of ICT equipment used to implement services will also be addressed on the consent. This may include*:*
    a. Smart Devices
    b. Mobile Phones
    c. Computers with Video Camera
2) Written consent will also be obtained from the person served as required, for any audio recording, video recording, and photographing of the person
3) Decisions by staff on whether to use ICT for service delivery with the person served are based on:
    a. The person's initial an ongoing assessment.
    b. Risk assessments.
    c. Under what conditions and circumstances, it is safe and effective to utilize ICT to deliver services.
    d. Periodic assessments of the person served for appropriateness of continuing ICT to deliver services will be done once a month.
    e. The identification of any changes in the person's condition or their environment, or the need to provide in-person services may warrant discontinuation of ICT.

4) Prior to the start of ICT service delivery Program Director or ACT Team Leader will confirm that the person served has all the equipment/technology to initiate and to continue services. The equipment/technology must be in working order throughout services. This includes the equipment/technology at the originating site for services, and the remote location.
5) As appropriate, instructions and training on ICT service delivery and equipment is provided to persons served, family/support, and others. This includes equipment training on:
    a. Features.
    b. Setup.
    c. Use.
    d. Troubleshooting.
6) Personnel will be available to provide technical assistance with accessing ICT for service delivery.
7) Personnel will respond to questions from persons served at the time they receive services. The person served will also be given contact information for staff they may reach out to if they have questions between their sessions.
8) If the person served has identified needs related to ICT delivery of services:
    a. An appropriate facilitator will be at the site where the person is located. This facilitator may be family/support, caregivers, professional personnel, or others as appropriate to the needs of the person and the type of session. Consideration should be given to the person served preferences for the facilitator.
    b. There may be modification to:
        i. Treatment approaches, techniques, and interventions.
        ii. Equipment including the use of assistive technology.
        iii. Materials provided.
        iv. The remote environment including accessibility, privacy, and usability of equipment.
9) Prior to the beginning of each session, all participants from the originating site and the remote location will identify/introduce themselves. Staff will also provide information that is relevant to the session.

10) Equipment is maintained according to the manufacturer's recommendations and records documenting the maintenance preformed will be in *(Insert location here.)*

11) Sessions are documented in the record of the person served as per the organization's documentation policy and timeframe.

E. **Emergency Procedures:**

It is critical that ICT service delivery is performed at remote sites that are safe and there are mechanisms and procedures to respond to emergencies. These include

1) Inquiries will be made by staff to determine if there are emergency procedures available at the remote site. Staff delivering services via ICT should be aware of those procedures, and support implementation as able from their location.
2) For the remote location of the person served, staff should identify local emergency service, emergency resources, and contacts including phone numbers. They should also have immediate access to the person served emergency contact information.

F. Staff Training and Competencies:

Staff who provide services using ICT will receive documented training and will demonstrate competencies on how to deliver services effectively using ICT. Training will be provided before they begin service provision using ICT. Competencies will be completed and documented following initial training, and *at* least annually thereafter.

1) Effective service delivery training may include:
    a. How to deliver services remotely.
    b. How to teach persons served, family/support about ICT service delivery.
    c. Technology needed to delivery services.
2) Training on equipment includes:
    a. Features.
    b. Setup.
    c. Use.
    d. Maintenance.
    e. Safety.
    f. Infection control based on the type of equipment used, and the remote location where the person served is receiving services.
    g. Troubleshooting problems.

Other resources:

- Northeast Telehealth Resource Center, *Roadmap for Planning Development of Telehealth Services, https://netrc.org/wp-content/uploads/2015/04/NETRC-Roadmap-for-Planning-Development-of-Clinical-Telemedicine-Services-2014.pdf* .
- National Association of State Mental Health Program Directors, *Technology's Acceleration in Behavioral Health: COVID, 988, Social Media, Treatment and More, https://www.nasmhpd.org/sites/default/files/4.%20Technology%20Acceleration%20in%20Behavioral%20%28Phillippi%29.pdf* .

Policy 11.04 - Internet, E-Mail, and Computer Use Policy

A. Policy Statement

1. The use of ACR Health Services (ACR) electronic systems, including computers, fax machines, and all forms of Internet/intranet access, is for ACR Health Services business and for authorized purposes only. Brief and occasional personal use of the electronic mail system or the Internet is acceptable as long as it is not excessive or inappropriate, occurs during personal time (lunch or other breaks), and does not result in expense or harm to ACR Health Services or otherwise violate this policy.

2. Use is defined as "excessive" if it interferes with normal job functions, responsiveness, or the ability to perform daily job activities. Electronic communication should not be used to solicit or sell products or services that are unrelated to ACR Health Services' business; distract, intimidate, or harass coworkers or third parties; or disrupt the workplace.

3. Use of ACR Health Services computers, networks, and Internet access is a privilege granted by management and may be revoked at any time for inappropriate conduct carried out on such systems, including, but not limited to:

a) Sending chain letters or participating in any way in the creation or transmission of unsolicited commercial e-mail ("spam") that is unrelated to legitimate ACR Health Services purposes;

b) Engaging in private or personal business activities, including excessive use of instant messaging and chat rooms (see below);

c) Accessing networks, servers, drives, folders, or files to which the employee has not been granted access or authorization from someone with the right to make such a grant;

d) Making unauthorized copies of ACR Health Services files or other ACR Health Services data;

e) Destroying, deleting, erasing, encrypting, or concealing ACR Health Services files or other ACR Health Services data, or otherwise making such files or data unavailable or inaccessible to ACR Health Services or to other authorized users of ACR Health Services systems;

f) Misrepresenting oneself or ACR Health Services;

g) Violating the laws and regulations of the United States or any other nation or any state, city, province, or other local jurisdiction in any way;

h) Engaging in unlawful or malicious activities;

i) Deliberately propagating any virus, worm, Trojan horse, trap-door program code, ransomware, or other code or file designed to disrupt, disable, impair, render

inaccessible, or otherwise harm either ACR Health Services' networks or systems or those of any other individual or entity;

j) Using abusive, profane, threatening, racist, sexist, or otherwise objectionable language in either public or private messages;

k) Sending, receiving, or accessing pornographic materials;

l) Becoming involved in partisan politics;

m) Causing congestion, disruption, disablement, alteration, or impairment of ACR Health Services networks or systems;

n) Maintaining, organizing, or participating in non-work-related Web logs ("blogs"), Web journals, "chat rooms", or private/personal/instant messaging;

o) Failing to log off any secure, controlled-access computer or other form of electronic data system to which you are assigned, if you leave such computer or system unattended;

p) Using recreational games; and/or

q) Defeating or attempting to defeat security restrictions on ACR Health Services systems and applications.

4. **Important exception:** consistent with federal law, you may use ACR Health Services' electronic systems in order to discuss with other employees the terms and conditions of your and your coworkers' employment. However, any such discussions should take place during non-duty times and should not interfere with your or your coworkers' assigned duties. You must comply with a coworker's stated request to be left out of such discussions.

5. Using ACR Health Services electronic systems to access, create, view, transmit, or receive racist, sexist, threatening, or otherwise objectionable or illegal material, defined as any visual, textual, or auditory entity, file, or data, is strictly prohibited. Such material violates ACR Health Services anti-harassment policies and subjects the responsible employee to disciplinary action. ACR Health Services' electronic mail system, Internet access, and computer systems must not be used to harm others or to violate the laws and regulations of the United States or any other nation or any state, city, province, or other local jurisdiction in any way. Use of ACR Health Services resources for illegal activity can lead to disciplinary action, up to and including dismissal and criminal prosecution. ACR Health Services will comply with reasonable requests from law enforcement and regulatory agencies for logs, diaries, archives, or files on individual Internet activities, e-mail use, and/or computer use.

6. Unless specifically granted in this policy, any non-business use of ACR Health Services' electronic systems is expressly forbidden.

7. If you violate these policies, you could be subject to disciplinary action, up to and including dismissal.

B. Ownership and Access of Electronic Mail, Internet Access, and Computer Files; No Expectation of Privacy

1. ACR Health Services owns the rights to all data and files in any computer, network, or other information system used in ACR Health Services and to all data and files sent or received using any ACR Health Services system or using ACR Health Services' access to any computer network, to the extent that such rights are not superseded by applicable laws relating to intellectual property. ACR Health Services also reserves the right to monitor electronic mail messages (including personal/private/instant messaging systems) and their content, as well as any and all use by employees of the Internet and of computer equipment used to create, view, or access e-mail and Internet content. Employees must be aware that the electronic mail messages sent and received using ACR Health Services equipment or ACR Health Services-provided Internet access, including web-based messaging systems used with such systems or access, are not private and are subject to viewing, downloading, inspection, release, and archiving by ACR Health Services officials at all times. ACR Health Services has the right to inspect any and all files stored in private areas of the network or on individual computers or storage media in order to assure compliance with ACR Health Services policies and state and federal laws. No employee may access another employee's computer, computer files, or electronic mail messages without prior authorization from either the employee or an appropriate ACR Health Services official.
2. ACR Health Services uses software in its electronic information systems that allows monitoring by authorized personnel and that creates and stores copies of any messages, files, or other information that is entered into, received by, sent, or viewed on such systems. There is no expectation of privacy in any information or activity conducted, sent, performed, or viewed on or with ACR Health Services equipment or Internet access. Accordingly, employees should assume that whatever they do, type, enter, send, receive, and view on ACR Health Services electronic information systems is electronically stored and subject to inspection, monitoring, evaluation, and ACR Health Services use at any time. Further, employees who use ACR Health Services systems and Internet access to send or receive files or other data that would otherwise be subject to any kind of confidentiality or disclosure privilege thereby waive whatever right they may have to assert such confidentiality or privilege from disclosure. Employees who wish to maintain their right to confidentiality or a disclosure privilege must send or receive such information using some means other than ACR Health Services systems or ACR Health Services-provided Internet access.
3. ACR Health Services has licensed the use of certain commercial software application programs for business purposes. Third parties retain the ownership and distribution rights to such software. No employee may create, use, or distribute copies of such software that are not in compliance with the license agreements for the software. Violation of this policy can lead to disciplinary action, up to and including dismissal.
4. **Confidentiality of Electronic Mail**

    a) As noted above, electronic mail is subject at all times to monitoring, and the release of specific information is subject to applicable state and federal laws and ACR Health Services rules, policies, and procedures on confidentiality. Existing rules, policies, and procedures governing the sharing of confidential information also apply to the sharing of information via commercial software. Since there is the possibility that any message could be shared with or without your permission or knowledge, the best rule

to follow in the use of electronic mail for non-work-related information is to decide if you would post the information on the office bulletin board with your signature.

b) It is a violation of ACR Health Services policy for any employee, including system administrators and supervisors, to access electronic mail and computer systems files to satisfy curiosity about the affairs of others, unless such access is directly related to that employee's job duties. Employees found to have engaged in such activities will be subject to disciplinary action.

5. **Electronic Mail Tampering:** Electronic mail messages received should not be altered without the sender's permission; nor should electronic mail be altered and forwarded to another user and/or unauthorized attachments be placed on another's electronic mail message.

6. **Policy Statement for Internet/Intranet Browser(s)**

a) The Internet is to be used to further ACR Health Services' mission, to provide effective service of the highest quality to ACR Health Services' customers and staff, and to support other direct job-related purposes. Supervisors should work with employees to determine the appropriateness of using the Internet for professional activities and career development. The various modes of Internet/Intranet access are ACR Health Services resources and are provided as business tools to employees who may use them for research, professional development, and work-related communications. Limited personal use of Internet resources is a special exception to the general prohibition against the personal use of computer equipment and software.

b) Employees are individually liable for any and all damages incurred as a result of violating ACR Health Services security policy, copyright, and licensing agreements.

c) All ACR Health Services policies and procedures apply to employees' conduct on the Internet, especially, but not exclusively, relating to: intellectual property, confidentiality, ACR Health Services information dissemination, standards of conduct, misuse of ACR Health Services resources, anti-harassment, and information and data security.

7. **Personal Electronic Equipment**

a) ACR Health Services prohibits the use in the workplace of any type of camera phone, cell phone camera, digital camera, video camera, or other form of recording device to record the image or other personal information of another person, if such use would constitute a violation of a civil or criminal statute that protects the person's right to be free from harassment or from invasion of the person's right to privacy. Employees may take pictures and make recordings during non-working time in a way that does not violate such civil or criminal statutes. ACR Health Services reserves the right to report any illegal use of such devices to appropriate law enforcement authorities.

b) Due to the significant risk of harm to ACR Health Services' electronic resources, or loss of data, from any unauthorized access that causes data loss or disruption, employees should not bring personal computers or data storage devices (such as floppy disks, CDs/DVDs, external hard drives, USB / flash drives, "smart" phones, iPods/iPads/iTouch or similar devices, laptops or other mobile computing devices, or

other data storage media) to the workplace and connect them, via any means, to ACR Health Services electronic systems unless expressly permitted to do so by ACR Health Services. To minimize the risk of unauthorized access to or copying of confidential ACR Health Services business records and proprietary information that is not available to the general public, any employee connecting a personal computing device, data storage device, or image-recording device to ACR Health Services networks or information systems in any manner thereby gives permission to ACR Health Services to inspect the personal computer, data storage device, or image-recording device at any time with personnel and/or electronic resources of ACR Health Services' choosing and to analyze any files, other data, or data storage devices or media that may be within or connectable to the data-storage device in question in order to ensure that confidential ACR Health Services business records and proprietary information have not been taken without authorization. Employees who do not wish such inspections to be done on their personal computers, data storage devices, or imaging devices should not connect them to ACR Health Services computers or networks.

c) Violation of this policy, or failure to permit an inspection of any device under the circumstances covered by this policy, shall result in disciplinary action, up to and possibly including immediate termination of employment, depending upon the severity and repeat nature of the offense. In addition, the employee may face both civil and criminal liability from ACR Health Services, from law enforcement officials, or from individuals whose rights are harmed by the violation.

Policy 12.01 - Legal Procedures and Confidentiality Guidelines

POLICY:

A. It is the policy of ACR that the confidentiality of current and former persons served be protected throughout all legal procedures which may involve verbal and/or written communication between employees of the organization and outside legal entities.

B. The guidelines and procedures of this policy are followed with strict adherence to the legal requirements involved in the above noted communications. Employees will receive initial and ongoing training in the confidentiality guidelines of legal procedures to ensure that rights of the persons we serve are fully protected

PROCEDURES:

A. Duty to Warn:

1) Definition: The duty to warn is defined as a person served revealing by any means a specific and immediate threat to cause serious bodily injury or death to an identified person(s), including self, and the person receiving the information reasonably believes that the person has the intent and the ability to carry out the threat immediately or imminently. The duty to warn supersedes all confidentiality laws.

2) In situations which involve a substance abuse diagnosis, Federal Law 42CFR, Part 2, requires that the duty to warn does not include disclosure or any inference concerning information that a third party could use to identify the individual as having a substance abuse diagnosis or problem.

3) If a public service employee is being requested to arrest, detain or transfer an individual known to have a communicable disease that may threaten the health of the public service employee, the following guidelines will apply:

1. Public safety employees should be made aware of the potential risk or exposure to a communicable disease without revealing the specific type of disease the individual is known to carry.

2. Communicable disease is defined as any airborne infection or disease as well as those transmitted by contact with blood or human body fluids.

3. Public safety employees are defined as any person with law-enforcement authority under the control of state and/or local governing bodies.

4. Employees involved in the situation should make every reasonable attempt to determine if the person served is known to be infected with a communicable disease by referring to the record, asking the individual directly, or consultation with other employees who have direct service contact with the individual.

5. Public safety employees must be informed of the "potential risk of exposure to a communicable disease" by communicating the necessary information to alert the public safety personnel of the risk, without disclosing the suspected or known condition.

4) Response to Imminent Threat or Danger: In the event that a decision is made to take precautions to protect due to an imminent threat of harm, employees should take the following actions:

1. Notify your supervisor for assistance, support, and consultation.

2. Warn the intended victim or the victim's parent if a minor

3. Contact law enforcement having jurisdiction in the area where the person served or intended victim live or work.

4. Attempt to prevent, through verbal means the individual from using violence until law enforcement can take custody.

5. Continue the interaction with the person making the threat if you judge that by doing so the person's intention to cause injury or death to self or other may be diminished to the extent the "duty to warn" is no longer valid.

6. If you judge the person to no longer be a threat requiring a "duty to warn", immediately seek consultation with a supervisor following the interaction to assess the level of continued contact or care that may be necessary to assure the situation has been stabilized.

7. Record the event in the individual's record and complete an Incident Report.

B. Subpoenas:

1) Definition: A subpoena is a mechanism for obtaining records from someone who is not a party to a legal case. It is a form of a court order that directs a person named to appear at a designated time and place to testify, produce documents, or both. In responding to subpoenas, ACR must balance our duty to protect confidential information against the duty to respond to the order of the court.

    1. A document subpoena or a "subpoena duces tecum" requires the person named in the subpoena to appear and produce documents.

    2. A subpoena to testify or a "witness subpoena" requires the person named in the subpoena to appear and give testimony.

2) A properly executed subpoena will require a response within the time frame noted on the document.

3) The recipient of a subpoena will immediately route it to the CEO who will review the document and ensure that it includes the following:

1. It is the original copy and is signed by the clerk of the court in which the action is pending.

2. It states the full name and address of the recipients of the subpoena as well as the action number and names of both the plaintiff and the defendant.

3. A "document subpoena" lists the documents to be produced as well as the time and place they are to be produced.

4. An officer authorized by law to execute the subpoena in the place where it is served it.

4) If the merit of the subpoena is questionable, the Program Manager will notify the CEO and forward the subpoena and will determine if ACR's legal counsel will be consulted for assistance. If the merit of the subpoena

   is questionable, contact will be made with the party who issued the document to determine if the information sought can be narrowed.

5) If a decision is made to contest the subpoena, ACR's legal counsel will pursue action to quash or modify the subpoena.

6) If a notice is received indicating that a motion has been filed to quash the subpoena, the records should be sent only to the clerk of the court issuing the subpoena using the following procedure:

   1. Place the records in a securely sealed envelope.

   2. Attach a cover letter to the sealed envelope, which states that confidential health care records are enclosed and are to be held under seal pending the court's ruling on the motion to quash the subpoena.

   3. Place the sealed envelope and the cover letter in an outer envelope or package for transmittal to the court.

7) If an individual's attorney issued the subpoena, the attorney should be asked to complete a Consent for Release of Information and have it

signed by the consumer to protect both the consumer and the organization.

8) Responding to a Subpoena:

1. All responses to subpoenas will be made with ongoing consultation with the supervisory personnel and the organization's legal counsel, if appropriate.

2. First, determine what records the subpoena seeks. If it seeks confidential records, confer with your supervisor and determine the statutes and regulations that apply to the records being sought.

3. If the records being sought are covered by Federal Law 42CFR, Part 2, governing substance abuse records, they may only be released if the subpoena is accompanied by a court order that complies with sections 2.61 through 2.64 of the law.

4. If the person is an active participant in services, notify them and/or their legal guardian of the request to ensure they have an adequate opportunity to assert his or her rights.

5. After informing the person served of the subpoena, determine if they have an interest in waiving confidentiality.

6. If the subject named in the document has consented to releasing the requested records, establish that all legal requirements have been met that permit the release of the records, and that specific details are available that communicate the exact documents or information that is to be released.

7. If documents are not confidential or you have a release from the person served, seek to excuse yourself from appearing by offering the records in advance of the proceeding. Never disclose any records in advance in which there are any questions concerning confidentiality.

8. Show up at the designated place and time noted on the subpoena.

9. Produce the designated documents at the designated place and time.

10. Refrain from disclosure of the records until you confer with the judge at the proceeding to determine whether the information should be released. In conferring with the judge, advise that the information sought is confidential and that the law prohibits you from disclosing it without a court order, and ask the judge to rule on whether records should be disclosed. Only if the judge orders you to disclose the information may you lawfully do so.

11. If you are appearing at a deposition in which a judge is not present, ACR management and or legal counsel will submit written objections to the release of confidential information in advance of the disposition if the person served has not consenter to the material's release.

12. Since the court may retain the originals while the case is pending, copies are to be made of all records sought by the court. These are to be maintained in the record until the original records are returned. If you are subpoenaed to a deposition, the party who issued the subpoena is responsible for having copies made and does not have the right to obtain the originals.

C. Subpoenas, Testimony, and Privileged Communication:

1) Definition: Privileged communication is conversation that takes place within the context of a protected relationship in which the disclosure of the content of that conversation may be deemed to do harm to the provider of the information. The concept of privileged as distinct from confidentiality is that it applies only to testimony in a judicial or quasi-judicial proceeding.

2) If an employee is subpoenaed to testify in a judicial proceeding, and information is requested that the employee believes is confidential or privileged, the subpoena does not authorize the employee to disclose the

information. The information may only be disclosed if a judge is present and rules that you must answer the questions.

3) If subpoenaed for testimony in a deposition and questioned about what you know or believe to be confidential or privileged information, decline to answer the question. The party seeking the information bears the responsibility of seeking a court order (judge's authorization) requiring the disclosure.

4) Confessions of past crimes within a confidential relationship will only be reported if the crime is of such a nature that the public welfare is jeopardized.

5) In civil matters, the parameters of privilege exist as defined by legal precedent and licensure requirements for licensed physicians and licensed clinical psychologist. Legal clarity is less defined for other mental health professionals and legal counsel will assist employees with preparation for testimony.

6) In all cases of testimony, employees should assert privilege by respectfully stating that he/she believes the information is privileged within the mental health provider/client relationship and allow the court to rule if he/she must respond to questions.

7) Under no circumstances should an employee testify regarding substance abuse treatment unless the court has conducted a hearing and issued an order pursuant to Federal Law 42CFR, Part 2.61. The employee in this circumstance will be represented by ACR legal counsel.

8) If, during the course of testimony, a judge orders the staff to reveal substance abuse related information, the employee should inform the judge that special federal law applies to such information and request the opportunity to confer with legal counsel.

D. Search Warrants:

1) Definition: A search warrant is a written court order that authorizes law enforcement officials to search a specific place for specific persons or materials. The search is conducted under the belief that there is probable cause to suspect that criminal activity or evidence of a crime may exist. Persons or items may be "seized" if they fit the description within the written order.

2) If a law officer presents a search warrant and demands to access records of persons served by the organization, the following guidelines should be followed:
    1. Immediately contact your supervisor and inform him/her of the search warrant.

    2. Ask to see and read the warrant and determine if it contains the following:

        i. The time and location of the search
        ii. The date of issuance of the search warrant
        iii. The scope of the search and the object (s) to be seized, if found
        iv. The reason for the search.

    3. The supervisor will notify ACR's legal counsel and request assistance with resolving the situation so that neither the individual's rights or the program's integrity is compromised.

    4. Ask the officers for time to contact the prosecuting attorney or supervisory law officer so that clarification of the warrant and the situation can be further discussed.

    5. If the officers insist on entry or confiscation of records, do not resist. Refusing to obey the orders may constitute a crime.

Policy 11.05 – Computer and Electronic Device Password Policy

I. POLICY:

A. It is the policy of ACR that complex passwords will be used on all electronic (company or personal) devices used to access or process ACR Health Services data, files or computer systems. It is especially important systems that contain Protected Health Information (PHI) have a complex password that controls access. This policy establishes a standard for the creation of complex passwords, the protection of those passwords and the frequency of change.

B. **Objective:** Passwords are an important aspect of computer security. They are the front line of protection for user accounts. A poorly chosen password may result in the compromise of ACR Health Services' entire corporate network. As such, all ACR Health Service employees (including contractors and vendors with access to ACR Health Service systems) are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

C. **Scope:** The scope of this policy includes all employees who have or are responsible for an account (or any form of access that supports or requires a password) on any system that resides at any ACR Health Service facility, who have access to the ACR Health Service network, or who store any nonpublic ACR Health Service information or PHI.

D.

II. PROCEDURES:

User Authentication

Every user must be assigned a unique user account (user ID) and a password for access to ACR Health Service systems. Shared or group user IDs are prohibited for user-level access. Systems and applications must authenticate using a password or token entry. The use of nonauthenticated user IDs (i.e., those without passwords) or user IDs not associated with a single identified user are prohibited. The account will lock a user out after six invalid login attempts within 30 minutes. Locked accounts shall remain locked for at least 30 minutes or until the System Administrator unlocks the account. Users may contact the IT Service Desk to have their account unlocked. Multifactor authentication is required for all users accessing ACR Health Service systems remotely.

Password Management

Passwords must be created and managed in accordance with this section.

Password Requirements

- All user-level ACR Health Service network passwords will expire every 90 days and must be changed.
- New passwords cannot be the same as the previous four passwords.
- Passwords must be at least eight characters in length. Longer is better.
- Passwords must contain both uppercase and lowercase characters (e.g., a-z and A-Z).
- Passwords must contain at least one number (e.g., 0-9).
- Accounts shall be locked after six failed login attempts within 30 minutes and shall remain locked for at least 30 minutes or until the System Administrator unlocks the account.

To unlock an account or change a password without logging in, some ACR Health Service systems require the Technology Department to provide a new temporary password to the user. In such cases, passwords must be provided verbally and the user must immediately log in and change the account password.

Passwords should not be shared with anyone, including IT support personnel, unless approved by the IT Security Specialist.

All passwords are to be treated as sensitive, confidential information. If someone requests your password(s), please inform him or her that you cannot provide that information per ACR Health Service policy and contact the IT Security Specialist about the request. If you suspect an account or password has been compromised, report the incident immediately and change all related passwords.

The Technology Department or authorized outside "penetration testers" may perform password cracking or guessing on a periodic or random basis to test the security of the ACR Health Service network. If a password is guessed or cracked during one of these scans, the user will be required to change it. Password cracking and guessing are not to be performed by anyone outside of the Technology Department or an approved third-party auditor.

The Technology Department strongly encourages the use of a password manager program to help ensure that all passwords are strong, unique and easily changed. Users should open an IT Service Desk ticket with a request for more information on password managers allowed on the ACR Health Service network and for assistance in getting the password manager installed and configured on their computer.

Guidelines for Password Construction

A complex password:

- Contains both uppercase and lowercase characters (e.g., a-z and A-Z).
- Contains digits and punctuation characters (e.g., 0-9 and !@#$%^&*).
- Is at least 8-15 alphanumeric characters long and is a passphrase (e.g., "Ohmy1stubbedmyt0e").
- Is not a single word in any language, slang, dialect or jargon (e.g., "password" or "Fluffy").
- Is not based on personal information, names of family members, etc.

Passwords should never be written down or stored online. Employees should try to create passwords that can be easily remembered. One way to do this is to create a password based on a song title, affirmation or other phrase. For example, the phrase might be "This may be one way to remember," and the password could be "TmB1w2R!" or "Tmb1W>r~" or some other variation.

Password reset/expiration period as follows:

1. 10-20 characters = no periodic reset/expiration required
2. 8-9 characters plus a second authentication factor = no periodic reset/expiration required
3. 8-9 characters only = annual password reset/expiration required

Use of Passwords and Passphrases for Remote Access Users

Access to the ACR Health Service network via remote access is to be controlled using either a one-time password authentication or a public/private key system with a strong passphrase.

Passphrases

Passphrases are generally used for public/private key authentication. A public/private key system defines a mathematical relationship between the public key that is known by all and the private key that is known only to the user. Without the passphrase to "unlock" the private key, the user cannot gain access.

Passphrases are not the same as passwords. A passphrase is a longer version of a password and is, therefore, more secure. A passphrase is typically composed of multiple words. Because of this, a passphrase is more secure against "dictionary attacks."

A good passphrase is relatively long and contains a combination of uppercase and lowercase letters as well as numeric and punctuation characters. An example of a good passphrase is "Vaca@The#OBX!$MyDreamin!"

All of the rules above that apply to passwords apply to passphrases.

Enforcement

Any employee found to be in violation of, or to have violated, this policy may be subject to disciplinary action, up to and including termination of employment.

Policy 12.02 - Program Participant Grievance Policy

I. POLICY:

A. It is the policy of ACR that the persons served are encouraged to state complaints and/or grievances if they believe their rights have been violated, and to pursue a resolution to their concerns in a structured format that provides fair and equitable results through due process.

II. PROCEDURES:

A. Persons served will be fully informed of the grievance procedures during their orientation to services. In addition, they will receive printed materials that will provide an overview of this process for later reference.

B. Day-to-day issues affecting the persons served shall be resolved informally between the person served and the primary staff member responsible for his/her service coordination. If the problem or complaint is not resolved to the satisfaction of the person served, the Advocate will adhere to the guidelines contained in this policy and assist the person served in accessing the procedures necessary to resolve the concern. Persons served or their families that need assistance in submitting a grievance or complaint may contact:

ACR's Advocate
4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032
404-508-0078
404-508-0071 (FAX)

C. Detailed step by step procedures and forms to submit grievances is contained in the Client Feedback Management System, ACR Policy 12.021.

D. Persons served have the right to due process with regard to grievances, and the organization will afford every reasonable opportunity for informal and/or formal resolution of the grievance.

E. Persons who may bring grievances include, but are not limited to:

1) The person served.

2) The guardian of the person served.

3) The attorney, designated representative, or a representative of a rights protection or advocacy agency of the person served.

F. A grievant shall in no way be subject to disciplinary action or reprisal, including reprisal in the form of denial or termination of services, loss of privileges, or loss of services as a result of filing a grievance.

G. Notices summarizing a person's right to due process in regard to grievances, including the process which grievances may be filed and copies of forms to be used for such purpose shall be available within each facility and program area.

H. Each person served will be informed of his/her right to grieve and the right to be assisted throughout the grievance process by a representative of his/her choice, in a manner designed to be understandable to the person served.

I. During a formal grievance procedure, the person served will have the right to the following:

1) Assistance by a representative of his/her choice.

2) Review of any information obtained in processing the grievance, except that which would violate the confidentiality of another person served.

3) Presentation of evidence of witnesses pertinent to the grievance.

4) Receipt of complete findings and recommendations, except those that would violate the confidentiality of another person served.

J. In all grievances the burden of proof shall be on the organization, facility, or program to show compliance or remedial action to comply with the policies and procedures established to ensure the rights of persons served.

K. All findings of a formal grievance procedure shall include:

1) A finding of fact.

2) A determination regarding the adherence of the organization, program, or employee, or the failure to adhere, to specific policies or procedures designed to ensure the rights of persons served.

3) Any specific remedial steps necessary to ensure compliance with organizational policies and procedures.

L. The steps of a formal grievance are as follows:

1) Formal grievances shall be filed first with the supervisor/director of the service unit or program in which the grievance arises.

2) A copy of the grievance shall be forwarded to the administrative head of the organization.

3) The supervisor/director of the service unit or program will meet with the grievant, and/or representatives, immediately following the filing to brainstorm resolution of any related issues that may get in the way of full participation in services. Actions may include, but not be limited to, a change in direct care providers or an adjustment in programming schedules and/or program environments.

4) The organization will issue a formal written response to the grievant, and/or the designated representatives, within five working days, excluding weekends or holidays, of the complaint.

M. The steps to appeal a written response to a grievance:

1) If the grievant is unsatisfied with the findings of the written response to a grievance, he or she may appeal the decision to the CEO within five days, excluding weekends or holidays.

2) The CEO will issue a formal written response to the grievant, and/or the designated representatives, within five working days, excluding weekends or holidays, of the complaint.

3) If the grievant is unsatisfied with the findings of the written response, he/she will be referred to a third party outside of the organization. Third parties may include organizations such as children's or adult protective services, professional licensing boards, nursing home ombudsmen, or other appropriate organizations that may serve as an advocate for the person served.

N. If the CEO does not resolve the complaint to the satisfaction of the grievant he/she may file a complaint/grievance at:

Region 3 Office of DBHDD at Georgia Regional Hospital-Atlanta
3073 Panthersville Rd,
Building 10, Decatur, GA 30034
404-244-5068

O. Grievances regarding the actions of specific staff members will be handled in accordance with personnel rules and contract provisions. No disciplinary action may be taken, nor facts found with regard to any alleged employee misconduct, except in accordance with applicable personnel rules and labor contract provisions.

P. A Grievance Log will be maintained by the organization detailing the nature of the complaint, relevant information obtained in the investigation, and the outcome of the process. All information contained will maintain the confidentiality of the participants in the process. This record will be reviewed annually by the Leadership Team to determine if there are trends in the complaints, and to identify areas to initiate performance improvement activities.

Q. Instead of following these procedures, complaints or grievances may be submitted directly to:

Region 3 Office of DBHDD at Georgia Regional Hospital-Atlanta
3073 Panthersville Rd,
Building 10, Decatur, GA 30034
404-244-5068

Or

Department of Behavioral Health & Developmental Disabilities
Office of Public Relations
2 Peachtree St. NW, 24nd Floor
Atlanta, GA 30303
404-657-5964
Email: DBHDDconstituentservices@dbhdd.ga.gov

Or

Georgia Advocacy Office in Atlanta
One West Court Square, Suite 625
Decatur, GA 30030
404-885-1234
800-537-2329 (toll-free in Georgia) (voice or TDD)
Email: info@thegao.org
Fax: 404-378-0031

Policy 12.02.1 - Program Participant Grievance Policy

Participant Feedback Management System

Policy:

Assertive Community Recovery is committed to providing an exceptional level of customer service throughout the organization. This includes responsiveness to the issues that are raised by our Participants, a responsibility that is shared throughout the organization, including senior management, directors, coordinators, managers, supervisors, all personnel and volunteers.

The Participant Feedback Management System is designed to facilitate timely customer problem identification and resolution. Its primary focus is to ensure that Participant feedback is received, problems are identified, communicated appropriately, and timely resolution and follow-through actions are performed and documented. The system is also designed to recognize employees who are complimented by our Participants. The information obtained from this process will be provided to the Leadership Team for evaluation of opportunities for improvement.

A. Definitions

1. **Participant Compliment:** any verbal or written acknowledgment of excellence in service provided at, or through, Assertive Community Recovery.

2. **Participant Complaint:** any verbal or written complaint or concern, which cannot be immediately addressed with a minimum amount of effort (usually within 10 minutes or less)--or isn't otherwise reportable under the Reporting an Unusual Occurrence policy.

B. Procedure:

Compliments

1. Compliments for excellence in service may be received either verbally or in writing, or through a survey process. All programs will be regularly surveyed during the course of each year.

2. Compliments should be forwarded to a supervisor for proper recognition to employee(s).

Complaints

1. If a Participant or a family member of a Participant decides to file a complaint, the employee contacted by the Participant or family member will give him/her a complaint form to complete. (see: attachments) If the complaint is received by

phone, the employee will complete the form. The employee who takes the complaint must inform the Participant / family member about the complaint process, i.e., they will be contacted within 48-72 hours. The complaint should be forwarded immediately to the appropriate immediate supervisor and the Quality Assurance Director.

2. If resolution cannot be achieved within three working days, the immediate supervisor who received the complaint will provide status updates to the Participant until the complaint is resolved. All information regarding the solution must be forwarded to the Quality Assurance Director.

Reporting

1. Quarterly and annual reporting of all complaints/compliments by area and categorical type will be presented to the Leadership Team.

2. Trends will be identified through the use of these reports and recommendations for action formulated.

3. Annual reviews at the management level will include an evaluation regarding the manager's responsiveness and adherence to the Participant Feedback Management System.

4. Quarterly Reports of all consumer complaints and grievances shall be submitted to the Region 3 Office of DBHDD by the 15th of the month following the quarter being reported. Reporting shall include the complaints and grievances received directly as well as those received through the Regional Office. The reports must include:

    a. Types and dates of all complaints and grievances;
    b. Originator of the complaint and grievances;
    c. Complaints and grievances new in the current quarter and those unresolved from previous quarters;
    d. Of resolved complaints and grievances, the numbers of unresolved from previous quarters;
    e. Days to resolution for each complaint or grievances;
    f. Disability and program involved; and
    g. Identified systems and corrective measures taken, if any.

Office: 404-508-0078 Fax 404-508-0071
email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

[*Intended use: For ACR Participant to complete*]

Participant Complaint Form

Participant's Name _____ Site

_____

Date of Complaint_____ Date of occurrence_____

Complaint form completed by: (check one)

___ Participant

___ Employee on behalf of Participant:

___ Other:_____(relationship to Participant):

Complaint filed: (check one)

___ In person

___ By telephone (Employee taking complaint sign below):

___ Other

Please explain your complaint

_____
_____
_____
_____
_____
_____
_____
_____

Which staff persons did you talk with about this complaint? _____

Do you feel the issue has been resolved? _____ Yes _____ No (If no explain – see section II)

_____
_____

Do you have any suggestions on how we should address the issue?

_____

_____

_____

Participant's Signature/Participant's "Other"
Signature:_____

Participant's Telephone Number: (_____) _____ - _____

If the above complaint was taken by a ACR staff member – ACR Staff member please sign below.

ACR staff member sign here (If applicable):_____

Participant Complaint Form, Section II [*This section is to be completed by ACR Staff only*]

ACTIONS TAKEN: (Include date & time)

_____

_____

_____

_____

_____

_____

_____

RESOLUTION: (Include date)

_____

_____

_____

_____

_____

IMPROVEMENTS MADE AS A RESULT OF PARTICIPANT FEEDBACK:

_____

_____

_____

_____

Staff Member's Signature:_____ Date:_____

Director's Signature: _____ Date:_____

Enter date copy forwarded to ACR QI Coordinator: Date:_____

Participant Complaint Form, Section III [*For: Program Manager Use Only*]

Preliminary investigation findings:

_____

_____

_____

Is this a Participant's right issue? ___ Yes ___ Questionable ____ No

If no, explain why and cite action(s) taken:

_____

_____

_____

If yes, (or questionable) what is the right allegedly violated?

_____

Was the complaint substantiated in the preliminary investigation?

___ Yes _____Questionable ___ No

If no, explain findings:

_____

_____

_____

If yes or questionable, indicate date of Summary Memo to supervisor:_____

Do you think that this complaint has been: Resolved _____ Unresolved_____

Staff member's signature:_____ **Date:**_____

Supervisor's signature: _____ **Date**: _____

Enter date copy forwarded to ACR QI Coordinator: Date:_____

Policy 12.03 - Rights of Persons Served

POLICY:

It is the policy of ACR to implement policies promoting the rights of its individuals, and communicate these rights to the individual in a way that is meaningful and understandable ACR is also committed to maintaining a policy by which individuals may formally complain to the organization, and communicating this procedure to its individuals.

PROCEDURES:

A. Upon orientation to the program, and periodically, individuals shall receive a copy of their Rights, Responsibilities, and Complaints after a thorough explanation of these rights. ACR shall maintain documentation that individuals have been given their rights in the orientation check sheet. ACR shall also keep posted copies of these rights in a central location for review on an ongoing basis.

B. In compliance with the organization's policies, and procedures, ACR individual rights shall include, at minimum:

1) Confidentiality of records
2) Privacy
3) Right to be treated in an environment free from physical abuse, sexual abuse, physical punishment, or psychological abuse by threatening, intimidating, harassing, or humiliating actions on the part of staff.
4) Freedom from abuse, exploitation, retaliation, humiliation, and neglect
5) Access to information in a timely fashion needed to facilitate decision making
6) Informed consent or refusal of services, treatment, concurrent services, participation in research, or release of information
7) Expression of choice regarding the composition of the service delivery team
8) Access or referral to legal entities at the individual's expense
9) Access to information pertinent to the individual in sufficient time to facilitate his or her decision making
10) Access and referral to self-help/ advocacy support services

11) Adherence to research guidelines and ethics, if applicable
12) Investigation and resolution of alleged infringement of rights
13) Right to be free of physical holds (emergency intervention), seclusion, or restraint
14) Right to be involved in treatment planning, review of the plan, and notification of changes to the plan
15) Right to be involved in transition planning
16) Right to file grievances without fear of reprisal
17) Right to obtain copies of the program's licensing, inspection, and accreditation reports upon written request within 30 days
18) Right to request in writing a review of the individual's file and receive a response within 30 days; ACR shall make the determination using up-to-date HIPAA guidelines.
19) Right to retain personal property that does not jeopardize the safety of others, and the responsibility to keep all weapons and illicit and licit drugs away from the facility
20) Right to be informed of all rights, and exercise rights without reprisal in any form, including continued, uncompromised access to services. Rights should be distinguished from privileges, which may be revoked or revised at any time. Individuals may follow the grievance procedure to appeal restrictions placed on privileges. ACR shall review these grievances in accordance with the grievance procedure.
21) Right to receive services conducted in a manner reflecting quality professional and ethical standards of practice, and shall be apprised of the organization's code of ethics/conduct.
22) Right to receive services without discrimination based on race, color, sex, sexual orientation, age, religion, national origin, domestic/marital status, political affiliation or opinion, veteran's status, physical/mental handicap or ability to pay for services.
23) Access to written information about fees for services and their rights regarding fees for services, and will not be refused services due to an inability to pay.
24) Right to an explanation if services are refused to them for any reason including admission ineligibility or continued care ineligibility, and have the right to appeal such decisions.

25) Right to informal complaint and/or formal grievance of practices or decisions that impact their treatment or status without fear or concern for reprisal by the organization or its staff, and have the right to have this process clearly communicated to them upon entry to services and throughout participation in services.

26) Persons served have the right to be informed of appeal procedures, initiate appeals, have access to grievance procedures, receive a grievance appeal decision in writing, and appeal a grievance decision to an unbiased source.

27) Persons served have the right to be protected from the behavioral disruptions of other persons served.

28) Right to access guardians, self-help groups, advocacy services and legal services at any time. Access will be facilitated through the person responsible for the individual's service coordination.

C. INDIVIDUAL RESPONSIBILITIES

1) The responsibility to treat other individuals and employees with courtesy.

2) The responsibility to behave in such a way as to protect themselves and others from exposure to or transmission of, any infectious or communicable disease, including diseases that are sexually transmitted.

3) The responsibility to make their concerns known to ACR staff and to ask questions when they require information from staff.

4) The responsibility to follow all of ACR safety rules and posted signs.

Policy 12.04 - Release of Information

POLICY:
To define a formal policy of the agency to obtain from or release to any organization or individual any information pertaining to persons served.

PROCEDURES:

Information pertaining to any individual shall be obtained from or released to any organization or individual, according to the following criteria:

A. That the individual's right to confidentiality is protected, according to applicable laws and regulations.

B. That information requested by or released from the program is limited to documented specific needs for, and/or purpose of the documentation.

C. That content of records cannot be simply duplicated and forwarded as a means of providing information. Relevant material should be summarized according to the specified needs for information.

D. That forms for authorization of release of information are limited by time

Policy 12.05 - Advance Directives

I. POLICY:

It is the policy of Assertive Community Recovery (ACR) to support individuals in exercising their rights to have input into their treatment, care and services including the right to decline medical treatment or direct that it be withdrawn and to establish psychiatric advance directives. A competent adult individual is informed of his/her right to formulate an advance directive such as a Psychiatric Advanced Directive, Living Will, or Durable Power of Attorney for Healthcare in the event that he/she becomes disabled, incapacitated or incompetent due to a psychiatric emergency, terminal condition, coma or persistent vegetative state.

The discussion of Advance Directives is done at the time of assessment and admission to services. If a individual requests a Psychiatric Advance Directive, an appointment will be scheduled with an ACR staff member. Discussion of advance directives may not be appropriate for some individuals at the point of admission and may be addressed at a more appropriate time in the course of care, treatment and services.

II. DEFINITIONS:

A. **Advance Directive**: A written document in which people clearly specify how medical decisions affecting them are to be made if they are unable to make them, or to authorize a specific person to make such decisions for them.

B. **Psychiatric Advance Directive:** A relatively new legal instrument that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment, in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

C. **Living Will:** A legal document that a person uses to make known his or her wishes regarding life prolonging medical treatment.

III. PROCEDURES:

A. Advance Directives will be recognized by ACR, but the presence or absence of an Advance Directive will not hamper access to care.

B. A copy of the Advance Directive must be provided to ACR for inclusion in the clinical record where it is readily accessible by the treatment team.

C. If the individual/family/legal representative/personal agent requests further information on Advanced Directives, he/she will be provided the names/phone numbers of ACR staff that are trained in Advance Directives, as well as other community resources.

D. Advance Directives may be formulated, modified or revoked at any time in accordance with Georgia Code unless the individual requests a non-revocation clause during the development of the original document.

E. When a individual served is transferred to another healthcare provider or agency, information regarding his/her Advance Directive will be included in the transfer summary.

F. Sources for information on Advance Directives can be located at:

- National Alliance on Mental Illness (NAMI) https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Psychiatric-Advance-Directives-(PAD)
- CaringInfo http://www.caringinfo.org
- National Resource Center on Psychiatric Advance Directives https://www.nrc-pad.org/

Policy 12.06 - Alleged or Suspected Abuse and Neglect

I. POLICY:

A. It is the policy of ACR to report all instances of suspected abuse and neglect to the appropriate protective services department in accordance with Georgia statute. The statute provides immunity from civil or criminal liability for persons making reports of abuse in good faith.

B. Abuse and neglect for the purposes of this policy are defined as follows:

1. **Children:** Child abuse and neglect shall mean the harm or threatened harm to a child's health or welfare by a person responsible for the child's health or welfare. This includes, but is not limited to non-accidental physical injury and verbal, emotional, or sexual abuse. Persons responsible for a child's welfare can include a parent, legal guardian, custodian, foster parent, persons 18 years of age or older with whom the child's parent is cohabiting or any adult residing in the home; an agent/employee of a public/private residential home, institution or facility; or an owner, operator or employee of a child care facility. Reasonable suspicions shall be reported to either the Department of Family and Children Services and Department of Human Resources in the county in which the suspected abuse occurred.

2. **Elderly or Incapacitated Persons:** The abuse of elderly or incapacitated persons includes neglect and financial exploitation as well as physical, verbal, emotional, or sexual abuse. Reasonable suspicions shall be reported to DHR Division of Aging Services Adult Protective Services (APS). Abuse, neglect, or exploitation of a disabled adult or elder person is a felony crime in Georgia.

C. **Reporting Suspected Child Abuse:** If a child is in immediate danger (obviously being beaten or left alone overnight, for example), the police should be called immediately. In all other cases, reports should be made to the DFCS office in the county where the child lives.

D. **Reporting Suspected Elder or Disabled Person Abuse:** DHR Division of Aging Services Adult Protective Services (APS) handles reports of abuse, neglect, and/or exploitation of disabled adults (18-64) or elder persons (65+) who reside in the community. This includes any disabled adult / elder person who is a resident of Georgia or is currently located in Georgia who is believed to have been abused, exploited, or neglected by a caregiver or other individual or who is experiencing self-neglect and is in need of protective services.

1. In case of elderly or disabled adults, reports of abuse, neglect, and/or exploitation in the community should be made to:

   Division of Aging Services, Adult Protective Services
   Toll-Free: (888) 774-0152
   Within Metro Atlanta local calling area: (404) 657-5250

2. If a disabled or elder person resides in a nursing home, personal care home, or other long-term care facility, reports should be made to:

   Office of Regulatory Services:
   Toll-Free: (800) 878-6442
   Within Metro Atlanta local calling area: (404) 657-5728

   or to the **Office of the State Long-Term Care Ombudsman**
   Toll-free at 1-888-454-5826.

In emergency situations, please contact local law enforcement at 911.

II. PROCEDURE

A. All professional staff will have a functional knowledge of the statutes concerning confidentiality and reporting of suspected abuse and neglect in accordance with Georgia's Mandated Reporting law.

B. Professional staff will seek immediate consultation with their supervisor to seek validation of the suspected abuse and the reporting of the abuse to the appropriate authority.

C. All reports of suspected abuse or neglect will be made in a descriptive and objective manner, and will not contain statements of conjecture or conclusions related to the reported suspected abuse. The report will contain the following information, if obtainable:

   1. The name, address, age and sex of the person
   2. If a child, the name and address of the child's parents or other person responsible for care.
   3. The nature and extent of the abuse or neglect
   4. Any evidence of previously known or suspected abuse or neglect
   5. The name, address and relationship, if known, of the person who is alleged to have perpetuated the abuse or neglect

D. Any adult victim who reports or describes abuse or neglect will be advised to contact Adult Protective Services. In the event the victim is unable to take immediate action, staff with seek to immediately consult with their supervisor to seek validation before contacting the Adult Protective Services on behalf of the client, and will cooperate with Adult Protective Services during any investigation.

E. In the case of persons less than eighteen years of age who by report or appearance provide evidence to warrant suspicion that they have been abused or neglected, staff will seek validation with their direct supervisor and immediately contact Adult Protective Services.

F. Staff will document verbal, written, and/or observed evidence that results in suspicion of abuse or neglect in the appropriate record and complete an incident report as per policy and procedures. Documentation should describe the incident; include the time and date, the action taken as a result of the incident, and the name of the person to whom the report was made at the protective services entity.

G. Any employee who acts in a manner which results in a person served being abused or exploited, or who fails to report or take action on behalf of a person served when the employee has reason to suspect abuse or neglect is occurring, shall be subject to disciplinary action up to termination in accordance with ACR Policy 12.09 - Reports of Abuse, Neglect or Exploitation by Staff

Policy 12.07 Research on Person(s) Served

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to protect the dignity and safety of consumers participating in research and safeguard the interests of consumers participating in research.

II. PROCEDURES:

A. All research that involves consumers shall comply with all applicable Department of Behavioral Health and Developmental Disabilities (DBHDD) Rules and Regulations.

B. Research to be conducted shall require prior approval of the ACR CEO/Executive Director, Clinical Director and Medical Director. The research, along with all research protocols, are then submitted for approval or disapproval to DHR Institutional Review Board and Region 3 Office of MHDDAD. Research proposals must include the following:

1. A research design that documents the following:
    a) A statement of rationale
    b) A plan to disclose benefits and risks of research to the participating person;
    c) A commitment to obtain written consent of the persons participating; and
    d) A plan to acquire documentation that the person is informed that they can withdraw from the research process at any time.
2. If research is conducted there is evidence that involved individuals: are:
    a) Fully aware of the risks and benefits of the research;
    b) Have documented their willingness to participate through full informed consent;
    c) Can verbalize their wish to participate in the research;
    d) If the individual is unable to verbalize or otherwise communicate this information, there is evidence that a legal

representative, guardian or guardian ad-litem has received this information and consented accordingly.

3. Written informed consent for consumer's participation in any research project that shall become part of the consumer's record and consent may be withdrawn at anytime and shall be documented in the consumers' record.

C. ACR will not to use unusual medications, investigational or experimental drugs in the treatment of consumers.

Policy 12.08 - Involvement of Individuals in All Aspects of Care, Treatment and Services

I. POLICY:

It is the policy of Assertive Community Treatment, LLC (ACR) that the individual/family/legal guardian is involved in all aspects of care, treatment, and services throughout the course of treatment/care. The individual is given access to pertinent information about services in sufficient time to facilitate his/her decision-making and expression of choice.

II. PROCEDURES:

A. At assessment, the individual/family/legal guardian are encouraged to participate in the individual's individual service planning in order to adequately address the individual needs. Appropriate consent is obtained from the individual as needed.

B. ACR scope of services is based on the needs of individuals. The services available are explained to the individual.

C. A collaborative effort to develop an initial individual recovery plan, which involves the individual/family/legal guardian and appropriate staff, is developed. With individual consent, family/legal guardian will be involved in the ongoing treatment planning process.

D. Individual/family involvement is encouraged and promoted throughout all aspects of care, treatment, and services to ensure that the ongoing needs of the individual and family, if appropriate, are met. The individual may also invite other stakeholders to participate at any time.

E. Individuals will be informed the results of assessments in a language that he or she can understand. Team Leaders/Lead therapist will discuss the results of assessments when treatment plans are reviewed with individuals and their families.

F. Individual/family/legal guardian involvement is documented in the clinical record.

Policy 12.09 - Reports of Alleged Abuse, Neglect, or Exploitation by Staff

I. POLICY:

It is the policy of ACR to report all instances of suspected abuse and neglect will be taken serious and immediately investigated and/or reported to the appropriate authorities to protect consumers and also to protect staff from unwarranted complaints.

II. PROCEDURE

A. Any employee, volunteer, consultant, or student who knows of or has reason to believe that a consumer may have been abused, neglected, or exploited by a Assertive Community Recovery, LLC (ACR) employee, volunteer, consultant, contractor or student, will immediately report this information directly to the Clinical Director.

B. The Clinical Director will immediately take necessary steps to protect the consumer until an investigation is complete. This may include the following:

    1. Direct the employee or employees involved to have no further contact with the consumer. In the case of incidents of peer-on-peer aggression, protect the consumer from the aggressor in accordance with sound therapeutic practice and the Consumer Rights policies and procedures herein.

    2. Temporarily reassign or transfer the employee or employees involved to a position that has no direct contact with consumers.

    3. Temporarily suspend the involved employee or employees pending completion of an investigation.

C. If the Clinical Director suspects that a human rights violation may have occurred, the Executive Director is notified immediately. If the Clinical Director does not suspect that a human rights violation may have occurred, he/she will complete a written report with recommendation and/or how the complaint was resolved and submit to the Executive Director within ten (10) working days of the day the complaint was received by the Clinical Director.

D. The Clinical Director (or designee) will immediately notify the consumer advocate and the authorized representative, as applicable. In no case will notification exceed 24 hours from the receipt of the initial allegation of abuse, neglect, or exploitation.

E. In no case will the ACR punish or retaliate against an employee, volunteer, consultant, or student for reporting an allegation of abuse, neglect, or exploitation.

F. The Executive Director will initiate an impartial investigation within 24 hours. The investigation will be conducted by the Clinical Director, unless he/she is involved in the issues under investigation.

G. The Clinical Director will make a final report to the Executive Director or the investigating authority and to the consumer rights advocate within 10 working days of appointment. Exceptions to this timeframe may be requested and approved by the Executive Director if submitted prior to the close of the sixth day.

H. The Executive Director or investigating authority will, based on the investigator's report and any other available information, decide whether the abuse, neglect or exploitation occurred. Unless otherwise provided by law, the standard for deciding whether abuse, neglect, or exploitation has occurred is preponderance of evidence.

I. If abuse, neglect or exploitation occurred, the Executive Director will take any action required to protect the consumer and other consumers. All actions must be documented and reported as required. In all cases, the Executive Director will provide written notice, within seven working days following the completion of the investigation, of the decision and all actions taken to the consumer or the consumer's authorized representative, the consumer rights advocate, the investigating authority, and the involved employee or employees. The decision will be in writing and in the manner, format, and language that is most easily understood by the consumer.

J. If the consumer affected by the alleged abuse, neglect or exploitation or his/her authorized representative is not satisfied with the director's actions, he/she or his/her authorized representative, or anyone acting on his/her behalf, submit a complaint to DHR DBHDD or DBBHDD Region 3.

K. The Executive Director will cooperate with any external investigation including those conducted by DHR or other regulatory and enforcement agencies.

L. If at any time the Executive Director has reason to suspect that a consumer may have been abused or neglected, the Executive Director (or designee) will immediately report this information to the appropriate DFCS or Adult Protective Services and DBHDD as indicated in ACR Policy 9.02 - Risk Reduction and Critical Incident Reporting. Executive Director will cooperate fully with any investigation that results.

M. If at any time the Executive Director has reason to suspect that the abusive, neglectful or exploitive act is a crime, the Executive Director or designee will immediately contact the appropriate law enforcement authorities and cooperate fully with any investigation that results.

N. If allegations of abuse, neglect or exploitation are substantiated the employee involved will be subjected to disciplinary actions to include termination.

Policy 12.10 – HIPAA Individual Responsibility for Protection of Consumer Privacy and for the Security and Integrity of Protected Health Information

I. POLICY:

Each employee of Assertive Community Recovery, LLC (ACR) has a responsibility to consumers and ACR to uphold consumers' privacy rights, and maintain the security and integrity of their protected health information. Consumers' personal health information will be treated as confidential, and held, used and disclosed only within applicable regulations. All employees will collect, use, disclose, maintain and store consumers' protected health information in an honest, ethical, secure, and confidential manner.

BACKGROUND / PURPOSE:

To establish the requirements for each employee to protect consumers' privacy rights and safeguard their individually identifiable health information as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and all other applicable Federal regulations and interpretive guidelines.

II. PROCEDURES:

1. All ACR employees will uphold and safeguard the rights of consumers to the privacy of their personal health information by ensuring that individually identifiable information is used and disclosed only under the following conditions:
    1. The consumer or an authorized personal representative has been provided with a copy of the ACR's Notice of Privacy Practices (Form114), and has signed to confirm so. The Notice of Privacy Practices should be posted prominently at each service site and on the ACR's web site;
    2. The consumer or an authorized personal representative has read, completed and signed the ACR's consent for services (Form 04) in ALL sections - consent for services, family involvement, and follow-up contact;
    3. Staff will take all reasonable precautions to safeguard the confidentiality of consumers' protected health information.

4. Use and disclosure is permitted without specific authorization when required for treatment, payment, and healthcare operations on the terms set out in the current Notice of Privacy Practices (114);
5. Disclosure to any person or entity for other purposes may be made on written authorization of the consumer or, if appropriate, his/her parent or legal guardian. Authorization must be obtained using Form 03, which must be completed in full, see Disclosure of Health Information with Authorization (Policy 6.06);
6. Use and disclosure of health information for other purposes without authorization may be made only when required by law and under conditions set out in the current Notice of Privacy Practices (114) and Disclosure of Health information Without Authorization (Policy 6.05);
7. Service records of consumers treated for alcohol and drug abuse shall be maintained in accordance with Volume 42 of the Code of Federal Regulations 42, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, as now or hereafter amended. Volume 42 of the Code of Federal Regulations Part 2 and O.C.G.A 37-7-166 control the disclosure provisions for consumers treated for alcohol and drug abuse. Each disclosure or release of information made with the consumer's written authorization will be accompanied by a statement of Prohibition of Re-disclosure as contained in Section 2.32, 42 CFR, Part 2.

2. All ACR employees will comply with all applicable policies and procedures implemented to ensure the security and integrity of consumers protected health information (PHI).
3. After leaving their employment with ACR, ex-employees must continue to protect the privacy of consumers' health information. All departing employees must immediately return to their supervisor any and all documents and media containing confidential protected health information. They must also take care never to disclose without proper authorization any protected health information that they may recall after leaving employment with ACR. A signed copy of ACR Form 12.10a (Responsibility to preserve the confidentiality and security of HIPAA protected health information) will be obtained during New Employee Orientation and Human Resources Department will, at exit interviews, provide departing employees with a reminder of their consumer privacy responsibilities.
4. Non-compliance with this policy and associated procedures is a serious matter and may result in civil and criminal actions in addition to internal disciplinary action that could lead to dismissal from employment.

ACR Health Services Policy 12.11
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Assertive Community Recovery, LLC is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. Assertive Community Recovery, LLC is also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: Assertive Community Recovery, LLC may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

- For treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.
- For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.
- For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.
- Reminders for Scheduled Transports and Information on Other Services. We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or to provider information about other services we provide.

Use and Disclosure of PHI Without Your Authorization. Assertive Community Recovery, LLC is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment or health care operations activities of another health care provider who treats you;
- For health care and legal compliance activities;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence;
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process; For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals;
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights: As a patient, you have a number of rights with respect to your PHI,

including:

The right to access copy or inspect your PHI. This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect and copy your medical information, you should contact our privacy officer.

The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact our privacy officer.

*The right to request an accountin*g. You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you. Assertive Community Recovery, LLC is not required to agree to any restrictions you request, but any restrictions agreed to in writing are binding on Assertive Community Recovery, LLC

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. If we maintain a web site, we will prominently post a copy of this Notice on our web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: Assertive Community Recovery, LLC reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our privacy officer.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the

Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to our privacy officer.

Privacy Officer Contact Information:

Trese Harris
ACR Advocate
4151 Memorial Drive, STE 209C
Decatur, GA 30032
Office: 404-508-0078
FAX: 404-508-0071

Effective Date of the Notice: November 1, 2008

SIGNATURE of Individual/Guardian accepting services Date

PRINTED NAME of Individual/Guardian accepting services Date

Witness Date

POLICY 12.12 - HIPAA Disclosure of Health Information to Caregivers, Personal Representatives, and Parents / Guardians

POLICY:

It is the policy of Assertive Community Recovery, LLC to provide limited health information to individuals involved in the consumer's care when it is believed to be in the consumer's best interest, and to afford a consumer's personal representative the same rights and access to protected health information as the consumer is entitled to receive.

PROCEDURES:

A. Caregivers

The Health Insurance Portability and Accountability Act's (HIPAA) privacy regulation recognizes that a covered entity may find it necessary to disclose some of a consumer's protected health information (PHI) to another individual involved in the consumer's care. For instance, the regulation allows individuals other than the consumer—a friend, family member, relative, or neighbor—to pick up a consumer's prescription. It also permits a pharmacist to counsel that other individual on the medication, even though some of the consumer's PHI may be revealed to the individual in such a situation. Intake workers should try to anticipate this possibility and have such caregivers listed as participants in the consumer's signed consent for services. Nevertheless, disclosures of this type may be made without such consent if they are limited and should only be made when the provider believes it is in the consumer's best interest.

B. Personal representatives

1) An individual who is legally authorized, under state or other applicable law, to make health care decisions on behalf of a consumer is considered to be the consumer's "personal representative." Examples of personal representatives include individuals with health care power of attorney or general power of attorney for the consumer, a court appointed legal guardian, or, in cases where the consumer is deceased, the executor of the consumer's estate, next of kin, or other family member.

2) Under the privacy regulation, covered entities are required to treat a personal representative in the same way they would treat the consumer. A personal representative has the ability to act for the consumer and exercise the consumer's rights. In general, a personal representative may

acknowledge receipt of the Notice of Privacy Practices, authorize disclosure of the consumer's PHI, access the consumer's PHI, and request an accounting of disclosures.

3) In some circumstances, the personal representative's ability to act for the consumer may be limited. For instance, if the personal representative has broad authority to act on behalf of a consumer, as a legal guardian would, the personal representative must be treated the same as the consumer in regards to all aspects of the privacy regulation. However, if a personal representative is authorized to represent a consumer only on a specific matter, such as treatment for a life-threatening illness, the personal representative may only access PHI that is directly related to that illness.

C. Minors

1) Normally, a parent is considered the personal representative of a minor child and has the authority to act for the minor and exercise the minor's rights. For example, a parent can acknowledge receipt of the Notice of Privacy of Practices for the minor and can access the minor's medical records.

2) But there are certain circumstances in which a parent is not considered the personal representative of a minor. Under the privacy regulation, a parent is not considered the personal representative of his or her child when the minor consents to the health care and consent of the parent is not required under state or other law, when the minor obtains health care at the direction of a court or a person appointed by the court, when the parent agrees to a confidential relationship between the minor and a health care provider, or when the minor is emancipated.

3) Complications can arise when families split up, and there are custody disputes between parents. To help clarify entitlement to access a child's PHI, intake workers should seek to have both parents included as participants in the child's service plan wherever possible. If there is any doubt as to the status of an individual representing himself or herself as a personal representative of a child, then the privacy officer should be consulted before disclosing PHI.

D. Exceptions

While an individual who is legally considered a consumer's personal representative generally has the authority to act on the consumer's behalf and access the consumer's PHI, there are a few exceptions to this rule. If a provider believes that a consumer or minor is subject to abuse, neglect, or domestic violence by his or her personal representative or parent, or that treating the individual as the consumer's personal representative could endanger the consumer, the covered entity may choose not to treat the individual as the

personal representative. These decisions should be made on a case-by-case basis in consultation with the privacy officer.

POLICY 12.13 - HIPAA Disclosure of Consumer Health Information Without Required Authorization or Agreement

POLICY:

Assertive Community Recovery, LLC has appointed a Privacy Official who is responsible for processing all requests for disclosures of Protected health information (PHI) from external authorities in compliance with law and limited to the relevant requirements of that law. We recognize that we are not compelled to make disclosures by the Privacy Rule, but that we may do so without fear of further penalty under the Privacy Rule.

BACKGROUND / PURPOSE:

The Agency, in an effort to be compliant with the Privacy Rule of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for responding to requests for disclosure of PHI in compliance with law and limited to the relevant requirements of the law that do not require the initial authorization or prior consent of the client.

PROCEDURES:

A. The decision about whether to disclose without the individual's authorization or agreement will normally be made by the Privacy Officer in consultation with the treating professional or other direct care staff person involved in the individual's treatment. The Privacy Officer may delegate this responsibility to others in the organization pursuant to a standing order for disclosures that are routine or on a case-by-case basis and the Privacy Officer will contact the agency lawyer if legal assistance is needed.

B. Many of these disclosures need to be accounted for to the individual should they request a list of disclosures. Because of this it is very important that staff carefully record the date, the PHI disclosed, the reason for disclosure, and to whom the disclosure was made on Accounting for Disclosures Form (Form 143). This form should be filed under the Authorizations / Consents Tab of the consumer's record. The Agency must be able to account for disclosures for up to 6 years.

C. When a court order is required to disclose PHI, the Privacy Officer will review the requested PHI and proposed disclosure process. When appropriate, the Privacy Officer will consult with our agency's attorneys before releasing PHI pursuant to a court order or before declining to do so because the request is not in the form of a proper judicial order.

D. Whenever we are permitted to disclose PHI pursuant to a subpoena (see Policy 12.01-Legal Procedures and Confidentiality Guidelines), we will receive satisfactory assurances from the party issuing the subpoena that:

    1) reasonable efforts have been made by such party to ensure that the individual has been given notice of the request. Satisfactory assurances must include a written statement and documentation that the party has made a good faith attempt to provide written notice to the individual, or if the individual's location is unknown, to mail a notice to the individual's last known address. The notice to the individual must include sufficient information about the proceeding to permit the individual to raise objections to the court. The time for the individual to raise objections must have elapsed with no objections filed or with all objections having been resolved by the court; or

    2) reasonable efforts have been made by such party to secure a qualified protective order. A qualified protective order means 1) a court order or stipulation of all parties to the proceeding that prohibits the parties from using or disclosing PHI for any purpose other than the proceeding for which the PHI was requested, and 2) requires the return to the agency or destruction of the PHI at the end of the proceeding. Satisfactory assurances, in this case, must include a written statement of the party and accompanying documentation demonstrating that the parties have agreed to a qualified protective order and have presented it to the court or that the party seeking the PHI has requested a qualified protective order from the court.

E. If we are uncertain as to whether the party requesting the PHI has adequately complied with the above requirements or if the requirements do not seem sufficient to protect the privacy interests of the individual, we will ask our lawyers to advise us about the proper method of disclosing PHI. We may decide, in connection with our legal consultation, to provide our own notice to the individual, to obtain an authorization from the individual, to seek a proper judicial order to release the PHI, to object to or request the court to quash the subpoena, or to seek our own qualified protective order.

F. In other cases the disclosure can be made without prior notice to the individual, but as soon as practicable afterwards, the individual must be informed that the disclosure was made. In all cases, the Privacy Officer in consultation with the treating professional or direct care provider will determine who should be responsible for notifying the individual about the disclosure. The notification, time, and date should be recorded on the Accounting for Disclosures Form (143) and signed by the individual responsible for notifying the individual. All

notifications to the individual about a disclosure may be made orally, but can be made using electronic or written communication.

G. Some of the disclosures discussed in this policy and procedure may be mandated by law. In these cases, the Privacy Officer should be informed of the disclosure, but does not need to approve it. Each individual who is mandated to report has a legal obligation to report that cannot be overruled by the opinion of another staff person. However, senior clinical staff as well as the Privacy Officer are available for consultation with any staff person who is unsure of whether or not a disclosure should be made.

H. In some cases, the staff person making the disclosure may believe that by disclosing to either the individual, to the individual's parents or guardians, or to others involved in the care of the individual, they are endangering the individual. In most of these cases, the staff person has an obligation to protect the safety of the individual and to not disclose even if it is permitted. Only professional treating staff should make this decision. Other direct care providers should consult with their clinical supervisor prior to exercising the agency's right to not disclose. The staff person should notify the Privacy Officer if possible prior to the decision not to disclose and in all cases within 48 hours after the decision is made not to disclose.

I. The following table lists the types of permitted disclosures, who can make the decision, and the notification requirements for each type

J. To request an accounting of disclosures, a consumer must submit the request in writing to the Privacy Officer. The request must state the time period for the accounting, and this time period should not be longer than six years, and not include dates before April 14 2003. The first accounting that a consumer requests within each calendar year will be free of charge. For additional requests during the same calendar year the consumer may be asked to pay the reasonable costs of providing the accounting. The consumer must be notified in writing of the amount to be charged, and given an opportunity to withdraw or modify the request for an accounting before any costs are incurred.

POLICY 12.14 - HIPAA Disclosure of Health Information with Authorization

POLICY:

It is the policy of Assertive Community Recovery (ACR) that any authorized disclosure of consumer personal health information be time limited, and specify the exact personal health information to be disclosed, and to whom.

BACKGROUND / PURPOSE:

To ensure disclosure of consumer health information by ACR is in compliance with Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines promulgated there under. See also Volume 2 of the Code of Federal Regulations 42, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, as now or hereafter amended, OCGA 37-7-166, Individual Responsibility for protection of Consumer Privacy (ACR Policy 12.10), Disclosure of Health Information Without Authorization (ACR Policy 12.13), and Privacy Practices Notice (Form 114, ACR Policy 12.11)

PROCEDURES:

A. Authorization for the disclosure of protected health information (PHI) should normally be sought using ACR Release of Information Form, written in plain language and specifying:

1) The full name of the consumer;
2) A specific and meaningful description of the PHI to be disclosed;
3) The purpose or need for the disclosure of PHI;
4) An expiration date or event for disclosure that relates to the purpose of the disclosure;
5) The person and/or agency to whom the PHI is to be disclosed;
6) A statement that the authorization is subject to revocation in writing by the consumer at any time unless protected health information has already been disclosed;
7) A description of how to revoke;

8) A statement that with the exception of information relating to substance abuse, the information disclosed may be subject to re-disclosure by the recipient and no longer protected by the Privacy regulations of HIPAA;

9) The witnessed signature of consumer or authorized representative, and the date of signature.

10) If signed by a representative, a description of the authority of that person to act for the consumer;

B. Each disclosure or release of PHI relating to substance abuse treatment made with the consumer's written authorization must be accompanied by a statement of prohibition of Re-Disclosure as contained in Section 2.32, 42 CFR Part 2.

C. Each time a disclosure of PHI is made that includes the entire medical record, the decision to disclose the entire record must be documented on the "Protected Health Information (PHI) Disclosure Log " (ACR form 12.14a) including the reasons why, and filed under the authorizations and consents tab in the medical record attached to the written request (if one is available). A copy of the documentation should be sent to the Privacy Officer.

1) If a written request is not available, the documentation should include the requestor's name, position, and agency or company, the stated reason for the request, the date, and the signature and name of the person making the disclosure.

2) This does not apply to disclosures made for treatment purposes, to a client, or pursuant to a client's authorization.

D. Authorizations for the disclosure of PHI not on ACR Release of Information Form may be accepted provided that all the points in A (A.1 to A.10) above are addressed.

E. A faxed or photocopy of a completed authorization form is acceptable by comparing signature of consumer on authorization to a signature within ACR records.

POLICY 12.15 - HIPAA Individual Confidentiality Regarding Photographs

POLICY:

It is the policy of Assertive Community Recovery (ACR) to preserve individuals' rights to privacy and confidentiality with regard to photography.

PROCEDURES:

A. ACR will not take photographs of any individual without the individual's written consent defining the intended use of the photograph, except for the specific purpose of individual identification to be maintained in the individual's record.

B. Photographs of individuals will be treated as protected health information, and maintained in a secure and confidential manner. With the written consent of a individual or their personal representative, pictures of a individual (with or without the individual's name) may be used in public displays and publications for the purposes only of celebrating individuals' achievements and accomplishments, publicizing the agency's services, or advocating for the communities and populations that the agency serves.

C. See Form 12.15a for consent to publication and public display of pictures and video / film recordings of individuals.

Consent to publication of photographs and film – Form 12.15a

Please have the individual complete this consent statement, and then place it in the individual's clinical record under the consent/authorization tab.

I, _____ (have client write name, or request staff assistance), hereby consent to being photographed and filmed while attending programs at Satilla Community Services. I further consent to the publication and / or public display of these photographs or film for the purposes of celebrating individual achievements, individual advocacy and / or raising awareness of the services provided by ACR.

I also consent to the publication my name alongside the images.*
*Initial if applicable [ ]

This consent is valid for a period of 90 days from the date of signing. I have the right to withdraw this consent to further photography, filming or publication at any point, save only those images already published under this consent that cannot be reasonably withdrawn.

_____ _____
INDIVIDUAL's SIGNATURE DATE

IF APPLICABLE:

_____ _____
SIGNATURE OF REPRESENTATIVE DATE

A REPRESENTATIVE SHOULD DESCRIBE HERE THEIR AUTHORITY TO ACT FOR THE INDIVIDUAL (E.G., LEGAL GUARDIAN,PARENT OF MINOR CHILD)

Reference Policy 12.15

POLICY 12.16 - Minimum Necessary Standard for Accessing, Using or Disclosing Health Information

POLICY:

Only individuals with a legitimate "need to know" may access, use or disclose consumer information. This includes all activities related to treatment, payment and health care operations on behalf of the agency. Each individual may only access, use or disclose the minimum information necessary to perform his or her designated role regardless of the extent of access provided to him or her

Definition: For the purpose of this policy, **protected health information** (PHI) means any individually identifiable health information collected or stored by a facility. **Individually identifiable health information** includes demographic information and any information that relates to past, present or future physical or mental condition of an individual.

BACKGROUND / PURPOSE:

To provide guidance regarding each individual's responsibility related to identifiable consumer information. This policy addresses intentional or unintentional breach of consumer confidentiality, **including oral, written and electronic communication**. This definition will safeguard consumer privacy and help minimize exposure and/or liability to individuals, and the agency. Each individual is responsible for adhering to this policy by using only the minimum information necessary to perform his or her responsibilities, regardless of the extent of access provided or available.

To establish the requirements for each program / service site to protect consumers' privacy rights and their individually identifiable health information as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and all Federal regulations and interpretive guidelines promulgated thereunder.

IMPLEMENTATION / PROCEDURE:

This policy is based on the following principles related to the access, use and disclosure of patient information.

1. Individuals acting on behalf of ACR must always use only the minimum amount of information necessary to accomplish the intended purpose of the use, access, or disclosure.

2. With respect to information access, consumer privacy will be supported through authorization, access, and audit controls (*e.g.*, roles-based access) and should be implemented to the extent practicable for all systems that contain identifying patient information. Within the permitted access, an individual system user is only to access what they need to perform his or her job. The matrix below will also serve as a chart tool access guide.

HIPAA ROLES-BASED ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

Advisory Board	PHI relating to incidents and complaints only. Access only via Privacy Officer or designee
CEO	All PHI of program caseload
Program Directors	All PHI of program caseload
Medical Director	All PHI of agency caseload
Physicians	All PHI of agency caseload
Nurses	All PHI of agency caseload
Pharmacy staff	All PHI of agency caseload
Site managers	All PHI for all consumers receiving services at their site
Case Managers / Counselors (all levels)	All PHI agency caseload
Training aides and non-credentialed / non-licensed direct care staff	All PHI except confidential information for all case load for their site
Support staff (including medical records staff)	Names and location where served for agency caseload, all PHI except confidential information for site caseload
Billing staff	All PHI of agency caseload
IT staff	All PHI for agency caseload
PI staff	All PHI for agency caseload
Archive staff (paper	Names, last service location, discharge summary for agency caseload

records)	
Admissions Unit	All PHI of agency caseload
All other staff	No access to PHI

3. Routine and recurring disclosures of PHI to individuals and organizations external to ACR will be made in accordance with the disclosure matrix below. All recipients of PHI will be required to sign a confidentiality statement, business associates or chain of trust agreement relating to the protection of consumers privacy rights, see POLICY 10.21-Business Associates). Recipients of service records of consumers treated for alcohol and / or drug abuse will in addition receive a statement of Prohibition of Re-disclosure as contained in Section 2.32, 42 CFR, Part 2, see HIPAA Individual Responsibility for Protection of Consumer Privacy and for the Security and Integrity of Protected Health Information (ACR Policy -12.10). Requests for information not covered by the matrix should be referred to the agency Privacy Official. It is important not to acknowledge even that the subject of the enquiry is a consumer of services, especially on programs treating addictive diseases. Upon request to release medical records, the medical record staff will review the notes for references such as, but not limited to, HIV/AIDS, traumatic events that could potentially result in consumer relapse, or notes that indicate a Child Protective Service/Adult Protective Service report to determine the need for a clinical review before the PHI is released.

HIPAA ROUTINE DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Disclosure Type	Type of PHI	Recipient
SSI for benefit eligibility	assessment, diagnosis, financial	Case worker, consumer authorization required
3rd Party Payors	assessment, diagnosis, service plan	Authorized claims processor
Mandated State Reporting	demographics, assessment, diagnosis, discharge summary	Authorized data analyst
Service Authorization	assessment, diagnosis, service plan	APS Care Manager, Amerigroup, Cenpatico/Peachstate,

		Magellion/Wellcare, CareSoruce
Quality Control	assessment, diagnosis, service plan, activity notes, case management notes, progress notes	Authorized Auditor (APS, CARF, Department of Community Health, Medicaid / Medicare)
Public Housing Authorities	demographics, assessment, diagnosis, service plan	Case worker, specific consumer authorization required
Banking, for management of consumer personal finances	demographics, financial	Bank employees, consumer authorization required
Family members	assessment, diagnosis, service plan, progress notes, activity notes, case management notes	Family members, consumer authorization required

4. Consistent with HIPAA Individual Responsibility for Protection of Consumer Privacy and for the Security and Integrity of Protected Health Information (ACR Policy -12.10), the Privacy Official (PO) has the responsibility of facilitating compliance with these principles in conjunction with the Corporate Compliance Officer.

5. Each individual is responsible for attending ongoing education on consumer privacy and consumer rights as directed.

6. Each individual is responsible for compliance with these privacy policies and principles.

7. Enforcement will be consistent with the agency Corporate Compliance Plan and personnel policies and procedures.

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email: info@AssertiveRecovery.com

4151 Memorial Drive, STE 209-C
Decatur, Georgia 30032

POLICY 12.17 - HIPAA Right to Restrict Uses and Disclosures of Protected Health Information

POLICY:

Consumers will be provided the right to request restriction of certain uses and disclosures of their protected health information (PHI) that is contained within the designated record set. Exceptions include information compiled for use in civil, criminal or administrative actions, and information that is subject to prohibition by the Clinical Laboratory Improvements Amendments (CLIA). Requests for such restrictions must be made in writing to the Privacy Officer (PO). No other employee may process such a request unless specifically authorized by the PO. A determination to restrict uses or disclosures must be made very carefully to ensure the request can be met. The agency may deny a request under certain circumstances.

Emergency Treatment exception: If the agency agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or provider to use and disclose necessary information to treat the consumer.

BACKGROUND / PURPOSE:

To ensure consumers the right to request privacy restrictions on the use or disclosure of their (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines promulgated thereunder.

IMPLEMENTATION / PROCEDURE:

Requests for Restrictions and Timely Action

1. The agency must permit a consumer to request restrictions on the use and disclosure of PHI as contained in the designated record set. Requests for restrictions must be presented in writing.
2. The written request must be routed to the Privacy officer (PO). The PO and his or her designee are the only individuals who may agree to any such restriction.
3. The right to request restrictions and the process for making the request must be outlined in the Policy 12.11 - HIPAA Privacy Practices Notice.
4. The agency is not required to act immediately and should investigate its ability to meet the request prior to agreeing to any restriction.

The consumer's request and the letter notifying the consumer of the PO's decision must be filed with the permanent medical record.

Providing the Restriction

The PO must ensure that the request can be met and that the designated record set is flagged per agency procedure.

Denial of Request

1. The agency may deny any request.
2. The consumer must be notified of the denial.

Terminating a Restriction

The agency may terminate its agreement to a restriction, if:

1. The individual agrees to or requests the termination in writing;
2. The individual orally agrees to the termination and the oral agreement is documented; or
3. The agency informs the individual that it is terminating its agreement to a restriction, except that such termination is only effective with respect to protected health information created or received after it has so informed the individual

POLICY 12.18 - HIPAA Confidentiality Procedures in Outpatient Clinics

POLICY:

Assertive Community Recovery will protect the privacy rights of consumers attending outpatient clinics.

BACKGROUND / PURPOSE:

To establish guidance for staff of ACR to protect the privacy rights of persons attending outpatient clinics.

PROCEDURE:

The manager / supervisor at each ACR service site will be responsible for ensuring that the following procedures are followed:

1. Every effort will be made to schedule visitor appointments during times when consumers are not present.
2. When it is necessary for visitors to be in facilities when consumers are present, visitors will be immediately escorted the office of the person visiting and the door closed. Visitors are not allowed to wait in common rooms when consumers are present.
3. In the case of emergency maintenance, consumers will be removed to another part of the building so that the repair work can be completed with no consumers present.
4. Every consumer and visitor should be asked on arrival at the clinic to complete the sign in sheet. There will be a separate sign-in sheet maintained for consumers and visitors. The check-in support staff should then mask the information to prevent unauthorized incidental disclosure of consumer information to subsequent consumers or visitors.
5. When calling the consumer from the waiting room, staff should use either the consumer's first or last name (not both), thus protecting the consumer's identity.
6. Staff should take reasonable precautions to ensure that discussions of consumer's health information cannot be overheard.
    a. If appropriate to the site, staff should consider privacy signs, requesting other consumers not to wait so close to the check-in desk that they can overhear exchanges of private health information. "For the privacy of the

person ahead of you, please wait behind this sign". Another possibility that might suit some sites would be to mark a line on the floor and ask consumers to wait behind it.

b. Review the sitting of telephones to reduce the likelihood of private telephone conversations being overheard

c. Review the sitting of computer monitors, fax machines and files, to minimize incidental disclosure of private information.

Policy 12.19 - HIPAA Individual Amendments to Clinical Records

POLICY:

It is the right of individuals to have the agency amend their Protected Health Information (PHI) that is contained within the designated record set for as long as the information is maintained by the agency.

A. The agency may deny a individual's request for amendment, if it determines that the PHI that is the subject of the request:

   1) Was not created by the agency, unless the originator of the information is no longer available to act on the requested amendment;

   2) The information or record is accurate and complete; or

   3) Is not part of the designated record set; or would not be available for access pursuant to the HIPAA - Right to Inspect and Copy (Policy, 12.20).

B. If the agency denies the request for amendment, the Privacy Officer (PO) must provide the individual with a written denial that outlines the reason for the denial.

DEFINITION: For the purpose of this policy, "amend" is defined as the individual's right to add to (or append) information with which he/she disagrees. It does not include deleting or removing or otherwise changing the content of the record.

BACKGROUND / PURPOSE:

To ensure individuals the right to amend protected health information (PHI) stored in the designated record set as required by the Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines promulgated

PROCEDURES:

Requests for Amendment and Timely Action

A. The agency must permit a individual to request an amendment to PHI as contained in the designated record set (Policy 27.04). The agency must require requests for amendment to be presented in writing as described in the current notice of

Privacy Practices (Form 114). The amendment should be filed in the medical record in the section containing the contested information.

B. The agency must act on a request to amend no later than 60 days after receipt.

1) If the agency is not able to meet the request to amend the record in 60 days the Privacy Officer (PO) must provide the individual with a written statement outlining the reasons for the delay and the date by If which the request will be met.

2) If it is foreseeable that the request cannot be met within 90 days, the agency Corporate Compliance Officer must be informed of the delay by the Privacy Officer no later than 5 business days prior to the deadline and must act to remediate the situation.

Accepting the Amendment

A. The following steps should be followed when accepting amendments to individual records:

B. The agency must make the appropriate amendment to the PHI by, at a minimum, identifying the records in the designated record set that are affected and appending or otherwise providing a link to the location of the amendment. In the case where the information is stored in another medium (e.g., microfilm, microfiche) a record of the link will be filed.

C. The agency must inform the individual in a timely fashion that the amendment has been accepted.

D. The agency must make reasonable efforts to inform and provide the amendment in a reasonable time to:

E. Persons identified by the individual as needing the amendment; or

F. Persons, including business associates, whom the agency knows, have the unamended information and who may have relied or could forseeably rely on such information to the detriment of the individual.

G. Amendments regarding services provided to the individual will be communicated to appropriate individuals in the billing department for review of potential billing issues.

Denying the Amendment

A. If the agency denies the request a timely, written denial to the individual must be provided by the Privacy Officer. The denial must contain:

B. The basis for the denial in accordance with the policy statement;

C. The individual's right to submit a written disagreement and how the individual may file such a statement;

D. A statement that the individual may request the agency to include the request and denial with any future disclosures of the information included in

the request for amendment; and

E. A description of how the individual may discuss the denial with the Privacy Officer, including address and telephone number, and the Secretary of HHS.

F. Statement of Disagreement: If a request for an amendment is denied then the individual may provide a statement of disagreement

G. If the individual submits a statement of disagreement, the Privacy Officer may provide a response statement to the individual. The Privacy Officer is encouraged to discuss the disagreement with Ageny's Counsel.

H. The agency must append or link the individual's request for an amendment, the denial, the statement of disagreement, and the written rebuttal to the specified designated record set.

I. Any future releases must include:

1) 1. The request for amendment and its denial; and

2) The statement of disagreement.

J. If a release is made in a standard electronic transaction the amendment may be separately transmitted via paper or fax.

K. Accepting Forwarded Amendments

If the agency is informed by another entity of an amendment this must be accepted into the designated record set.

Policy 12.20 - HIPAA Right to Inspect and Copy Clinical Record

POLICY:

Individuals will be provided the right to inspect and obtain a paper copy of their protected health information that is contained within the designated record set (Policy 27.04). Exceptions include information compiled for use in civil, criminal or administrative actions, and information that is subject to prohibition by the Clinical Laboratory Improvements Amendments (CLIA). The agency may deny a request under certain circumstances outlined in the procedure.

BACKGROUND / PURPOSE:

To ensure individuals the right to inspect and/or obtain a paper copy of their protected health information (PHI) as required by the Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines promulgated thereunder.

PROCEDURES:

A. Requests for Access and Timely Action

1) The agency must permit a individual to request access to or be provided with a paper copy of his or her protected health information as contained in the designated record set. The agency must require requests for access to be presented in writing.

2) Except as outlined below the agency must act on a request for access no later than 30 days after receipt.

3) Extenuating Circumstances:

a. If the agency is not able to provide access to the record in 30 days (60 days if offsite) the Privacy Officer (PO) or designee must provide the individual with a written statement outlining the reasons for the delay and the date by which the request will be fulfilled.

b. If it is foreseeable that the request cannot be met within 60 days (90 days if offsite) the Corporate Compliance Officer must be informed by the PO of the delay no later than 5 business days prior to the deadline and must act to remedy the situation.

B. If records have been destroyed in accordance with agency Records Retention Policy as outlined in Policy 27.01, the PO or designee must provide the individual with a written statement advising that the request cannot be fulfilled.

C. The following steps should be followed when providing individuals access to their records:

D. The agency must produce protected health information from the primary source or system as outlined in the designated record set definition (Policy 27.04)

E. The agency will provide a readable hard copy of the portions of the record requested. Online access may not be provided. Individuals with access to electronic records systems may not access their own record in any system. Such individuals must request access through the procedures outlined in this policy and must be provided with a paper copy.

F. A summary format may be provided if the individual agrees to the format and the associated fees.

G. The agency must offer the individual a convenient time and place to inspect or obtain a copy of the record or make arrangements to mail the copy.

H. Reasonable, cost-based fees may be imposed for copying, postage, and preparing a summary or explanation.

Denial of Access

I. The agency may deny access in the following circumstances. These are unreviewable grounds for denial.

J. If the agency is acting under the direction of a correctional institution and the information could jeopardize the health, safety, security, custody or rehabilitation of the individual, any officer, employee, or other inmates.

K. In the course of research that includes treatment, provided the individual has agreed to the denial of access when consenting to participate. The right of access will be reinstated upon completion of the research.

L. If the information that is contained in the records is subject to the Privacy Act, 5 U.S.C. Section 522a, and the denial meets the requirements of that law.

M. The agency does not maintain the information; however, if the agency knows where the information is maintained, the agency should inform the individual where to direct his or her request, if known.

N. The protected health information is exempted as outlined in the policy statement above.

O. A covered entity may deny an individual access, provided that the individual is given a right to have such denials reviewed as described below, in the following circumstances:

1) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;

2) The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional

judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

3) The request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

P. The agency must, to the extent possible, provide any other protected health information after excluding the information to which the agency has a ground to deny access.

Q. A timely, written denial to the individual must be provided from the PO or designee.

R. If the agency does not maintain the information requested by the individual and the agency knows where the information is maintained, the agency should inform the individual where to direct the request.

S. The individual may request a review of a denied request for access only under circumstances outlined in paragraphs O,1-3. The agency must promptly refer the request for review to a licensed health care professional who is designated by the covered entity to act as a reviewing official and who did not participate in the original decision to deny access. The reviewing official must determine, in a reasonable period of time, whether or not to deny the access requested. A written notice must be promptly provided to the individual outlining the outcome of the review.

Policy 12.21 - HIPAA Right to Confidential Communications

POLICY:

Assertive Community Recovery, LLC (ACR) will consider a individual's request for confidential communications upon request for same, for example, at intake.

We will document the alternative information and the approval on the intake/demographic form or equivalent electronic field. It will be our policy to grant reasonable requests. Reasonableness will be judged by the administrative difficulty of complying with the request.

We will not ask the individual to explain why they wish to have us communicate with them by alternative means or to alternative locations.

We will not comply with the individual's request unless they have provided us with complete information to enable us to communicate with them – i.e., a complete address or other method of contact.

We will provide adequate notice of the request to those employees who may need to contact the individual by flagging the medical record and, where possible, other individual databases..

BACKGROUND / PURPOSE:

The Agency, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for accommodating a individual's request for confidential communications.

PROCEDURES:

A. The individual's right to confidential communication will be explained in the Notice of Privacy Practices (Form 114).

B. Each individual will be asked at the time of their initial visit for each separate episode of care, if they wish to exercise their right to confidential communication. Normally, this responsibility will be assigned to the Intake Worker after the individual has been provided with a copy of the Notice of Privacy Practices (Form 114).

C. All requests for confidential communications will be reviewed and decided by the Privacy Officer or his / her designee immediately on receipt of the request.

D. If confidential communication is requested, the request and approval should be noted on the individual information/demographic form located at the front of the record and in the designated field in the electronic medical record. The following

information will be included with the demographic information in the medical record:

1) A copy of the individual's written request for confidential communications.
2) A copy of the Privacy Officer's written acceptance and agreement with the request.
3) A typed summary of how or where the individual wishes communications to be conveyed.

E. Approval for a confidential communication can only be given if the individual gives the organization adequate information to allow them to be contacted and makes adequate arrangements for services to be billed.

F. The following actions should be taken if a confidential communication has been requested and approved:

1) The outside of the paper medical record should be flagged with a sticker that states confidential communication.
2) Electronic records should have a field that flags the record as one where the individual has requested confidential communication.
3) Any other individual database, for example the billing database, should be flagged as well on the individual contact screen and other appropriate screens.

G. Prior to contacting the individual all employees should check one of the above to see if a flag exists. Employees who do not have access to any of the above three sources of information should not be responsible for contacting individuals.

Policy 12.22- Individuals Funds

I. POLICY:

It is the policies of Assertive Community Recovery, LLC (ACR) to educate and assist individuals in developing plans for management of individual valuables or funds in the manner that supports their individual recovery and stability in the community.

II. PROCEDURES:

A. ACR will not accept or manage the funds of individuals.

B. Individuals served will be provided education on budgeting, managing their financials and assistance in determining the money management supports needed to remain stable in the community.

C. When individuals are in the need of someone to manage their funds and/or valuables, ACR will assist the individual to locate persons outside the organization to serve as "representative payee" such as, but not limited to:

1. Family
2. Other person of significance to the individual
3. Other persons in the community not associated with the agency

D. ACR will document in progress notes the effort to secure a qualified, independent party to manage the individual's valuables and finances when the person served is unable to manage funds and there is no other person in the life of the individual who is able to assist in the management of individual valuables or funds.

E. The choice of persons to serve as "representative payee" is the individual. When requested by the individual, ACR will assist by locating resources in the community that the individual can select as their "representative payee."

Policy 12.23 - Communication with Persons with Limited English Proficiency

Assertive Community Recovery, LLC (ACR) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of ***ACR*** is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to the following:

- *Individual Served Orientation Checklist*
- *Individual Served Demographic Sheet*
- *Emergency Contact Form*
- *Informed Consent for Assessment and Treatment*
- *Consumer Bill of Rights*
- *Limits of Confidentiality*
- *Consumer Grievance Form*
- *Notice of Privacy Practices*
- *Transportation Authorization Form*
- *Authorization for Release of Information*
- *ACR Individual Served Hand Book*
- *ACR brochure*

All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

ACR will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, annually through strategic planning.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

ACR will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at http://www.lepsi.dhr.georgia.gov or www.lep.gov), as well as, posters, which are posted throughout the agency to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTEPRETER

ACR's office manager or delegate is responsible for:

> **(a)** Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff:
>
> ***(b)*** *Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;*
>
> ***(c)*** *Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language.*

All of the above mentioned staff may be contacted at: 404-508-0078 or TDD – 678-399-2026.

LATN contracted through Georgia Department of Human Services to provide qualified interpreter services is located at 1720 Peachtree Street, Suite 433, Atlanta GA 30309. The agency's telephone number(s) is 1-800-943-5286 and website address is http://www.latn.com.

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a). When translation of vital documents is needed, ***ACR*** will submit documents for translation into frequently-encountered languages to ACR's ***Utilization Manager.*** Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b). Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c). ***ACR*** will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

ACR will inform LEP persons of the availability of language assistance, free of charge, by providing languages LEP persons will understand. At a minimum, notices and signs will be posted written notice in and provided in intake areas and other points of entry, including ACR's Peer Center. Notification will also be provided through outreach documents and telephone voice mail menus.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, ***ACR*** will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, ***ACR*** will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from individuals served and community organizations via satisfaction surveys.

Policy 13.01 - Accessibility Plan Policy

I. POLICY:

It is the policy of ACR to promote accessibility and the removal of barriers for the persons served and other stakeholders. ACR is actively involved in accessibility planning that addresses the needs of consumers of services, employees and other stakeholders such as consumer advocates, community partners and referral sources. ACR addresses accessibility issues in order to accomplish its mission, to implement non-discriminatory employment practices, to comply with applicable regulations, and to meet the expectations of stakeholders in the area of accessibility.

It is ACR's policy that services be accessible to persons of all ages with all disabilities including physically disabled individuals with mobility difficulties, those with visual, hearing and language impairments, those with developmental disabilities including mental retardation, mental illness and addictive disease. ACR provides services without regard to race, creed, handicap, age, gender, national origin or religious preference. The organization abides by Title VI, Section 504 of the Americans with Disabilities Act. Request for Reasonable Accommodation will process in accordance with ACR Policy 13.01a – Request for Reasonable Accommodation.

ACR is committed to promoting the recruitment of persons with disabilities as Board members, employees, volunteers and contractors for the organization and to actively seek the input of the disabled population in the planning and implementation of programs and services. ACR embraces the ideal of a barrier-free society that promotes the independence, productivity and integration of persons with disabilities.

ACR's Accessibility Plan seeks to identify barriers in the areas of building architecture, environment, attitudes, finance, employment, communication, transport, and other areas in which consumers, employees or other stakeholders have identified accessibility issues.

II. PROCEDURES:

ACR will endeavor to remove architectural, attitudinal, cultural, physical, and other barriers for persons seeking employment or services, and other stakeholders by implementing the following:

A. The ACR will prepare an Annual Accessibility Plan to guide the identification and removal of barriers, to facilitate compliance with ADA requirements, and to promote cultural competence. The Plan will address barriers in the areas of building architecture, environment, attitudes, finances, employment,

communication, transportation, and in other areas identified by persons served, personnel, job applicants, board members and other stakeholders.

B. The Plan will specify actions for the removal of identified barriers, persons responsible, and timelines for the removal of these barriers.

C. The Accessibility Plan and progress in removing identified barriers will be regularly reviewed by the Performance Improvement Committee which will submit annually a written report to the Board on progress made in the removal of barriers, and areas needing improvement

III. Reasonable accommodations:

A. ACR evaluates and considers all requests for reasonable accommodations to its programs and services. Requests may be submitted either internally (i.e. via an employee, an individual served and/or their family, guardian, or advocate) or externally (i.e. via a community member, employer or referral source). After a request has been identified, it is reviewed, decided upon and documented by the CEO/Executive Director. If an accommodation for a person served cannot be made, referrals will be made to identify resources that are accessible.

B. Information regarding each request for accommodations is documented within ACR's annual status report on accessibility.

Policy 13.01a - Request for Reasonable Accommodation

I. POLICY:

ACR evaluates and considers all requests for reasonable accommodations to its programs and services. Requests may be submitted either internally (i.e., via an employee, an individual served and/or their family, guardian, or advocate) or externally (i.e., via a community member, employer or referral source). After a request has been identified, it is reviewed, decided upon and documented by the appropriate department. If an accommodation for a person served cannot be made, referrals will be made to identify resources that are accessible.

A. Reasonable Accommodation is a modification or adjustment to a ACR activity, program or service that enables a qualified individual with a disability to have meaningful access to those activities, programs and services unless doing so would result in an undue hardship, including hardship on ACR's operations or a fundamental alteration in the program.

B. A request for a Reasonable Accommodation may be made verbally or in writing to any staff of ACR.

II. PROCEDURES:

C. Once a request for a reasonable accommodation has been made, staff will provide the individual with the "Request for Reasonable Accommodation" form; instruct the individual to complete the form and/or assist the individual to complete the form.

D. Staff will forward the completed "Request for Reasonable Accommodation" form to the appropriate Clinical Director, or ACR's Advocate.

E. The Executive Director will make a determination and provide written notice of the determination, to the individual making the request. The written notice will include notice of how the individual may file a grievance if dissatisfied with the determination.

F. Determinations will be based upon the programs' ability to provide the accommodation without undue hardship including financial hardship or hardship in program operations.

G. All requests for reasonable accommodations and subsequent determinations, are documented and submitted to the Quality Assurance Officer. Requests for reasonable accommodations are reported on annually within the agency's annual report on accessibility.

H. Any grievances received, in response to a determination, will be forwarded to the Executive Director for review and resolution per ACR's Grievance Policy.

I. ACR Form 13.01.a.1 – Request for Accommodations will use to document the request and subsequent determinations of the request.

Policy 15.01 - Performance Measurement & Management Plan (PMMP)
January 1 to December 31, 2022

We need to speak a powerful message that reaches into the darkness and lets people know what is happening in the light ... People need to see the tangible thing that is recovery. — Bill Carruthers, Certified Peer Specialist (CPS)

Introduction

The following outlines the service delivery improvement plan for ACR Health Services. The purpose of the plan is to guide the collection of performance data on the services that the organization delivers and to support ongoing quality improvement.

ACR Health Services' quality improvement process is cyclical. The cycle planning for outcomes measurement (reflected in this document), doing data collection and checking the accuracy of the data, reflecting on results, and acting on the results (including reporting out to stakeholders). The process is represented graphically below:

Quality Improvement Cycle

Mission

The purpose of ACR Health Services (ACR) is to ensure that individuals with mental health and substance abuse needs receive the most appropriate and effective treatment in the least restrictive and most cost-efficient setting. ACR is not only committed to helping people live in the community, but also to help people live with the community. To that end, all services shall be focused around the principles of recovery, resilience and self-determination.

Values Statement

ACR is organized around core principle of delivering high quality treatment services in a way that is fully accessible and person centered. Pursuit of this principle is guided by a commitment to the provision of treatment that is comprehensive, community based, and delivered in the least restrictive setting with a focus on allowing individuals and their family to have their preferences known and to direct the delivery of treatment.

To fulfill these values, ACR adheres to and believes in the following guiding principles:

1. Family integrity is of paramount importance. Needs for security, permanency and cultural ties in family relationships should pervade all planning. Families should participate fully in all decisions concerning planning, placement, program and discharge.
2. ACR shall work with other social service agencies within its service area to achieve the best possible outcome for individuals.
3. ACR individuals shall participate fully in all service planning decisions. The uniqueness and dignity of the individual shall govern service decisions. Individualized Recovery Plans shall reflect the individual's developmental needs, which include family, emotional, intellectual, physical, social and cultural factors.
4. Culturally competent services will be guided by the concept of equal, responsive and nondiscriminatory services matched to the individual population. Cultural competence involves working with natural, informal support and helping networks within minority communities. Inherent in cross-cultural interactions are dynamics, which must be acknowledged, accepted and adopted.
5. Cultural competence extends the concept of self-determination to the community.
6. ACR recognizes that minority populations are at least bicultural and that this status creates a unique set of mental health and substance abuse issues to which the system must be equipped to respond. Thus the system must sanction and, in some cases, mandate the incorporation of cultural knowledge into practice and policy-making.
7. Individuals who have mental illnesses and/or substance abuse problems shall be treated with dignity and respect, as they have the same needs, rights and responsibilities as other citizens. Thus these individuals should have the same access to opportunities, supports and services to help them live successfully in the community. In this regard advocacy is one of ACR most important responsibility.
8. ACR services shall help individuals to empower themselves, focus on strengths, maintain a sense of identity and enhance self-esteem. Services should help people develop their potential for growth and movement towards independence.
9. ACR services shall meet the special needs of people with mental illness and/or substance abuse problems who are also affected by one or more of such factors as: old age, physical disability, homelessness, the AIDS virus and/or involvement in the criminal justice system.
10. ACR services shall be coordinated through mandated linkages with individuals/families, both at the local and state levels. Continuity of care for people discharged from hospitals to community-based services shall be ensured.
11. ACR shall be accountable to individuals and families, who should help plan, implement, monitor and evaluate the services they receive.

General Program Description:
Assertive Community Recovery, LLC, d/b/a ACR Health Services is an accredited privately owned behavioral health organization that supports the most underserved and vulnerable members of our communities. Founded in 2008, ACR operates a comprehensive network of clinical, therapeutic,

educational, and employment programs and services that positively impact the lives of hundreds of individuals and families every year. ACR provides an array of behavioral health and social welfare services for children, adolescents, adults and families in the Atlanta Metropolitan area. Our programs include outpatient counseling, in-home services, group therapy, alcohol and drug counseling, peer support, psychiatric assessments, nursing assessments, mediation management, and Assertive Community Treatment (ACT).

Overview of Performance Measurement & Management Plan (PMMP)

The PMMP focuses on performance improvement. It reenforces to leadership, management, and staff that performance improvement is valued in the culture of ACR Health Services. The plan focuses on accountability for high quality service delivery and business functions related to the services provided by ACR Health Services. This plan will be updated at least annually, and more frequently as needed.

The PMMP framework as outlined in this document:

1. Communicates ACR Health Services' high priority goals for service delivery and business functions of the services provided by ACR Health Services.
2. Identifies performance measures and indicators which will be used to evaluate these high priority goals.
3. Addresses reliable processes for implementation of this plan to include data collection for the measurement and monitoring of these written performance measures and indicators.
4. Offers targets for expected performance allowing for the comparison of expected results with actual results achieved.
5. Sets the expectation that:
    a. Data will be collected about the characteristics of persons served.
    b. Input will be obtained from persons served, family/support, volunteers, and stakeholders on what they would like to know about ACR Health Services and its programs.
    c. Persons served and stakeholder experiences and satisfaction with services will also be collected.
6. Creates the expectation that future actions will be documented, implemented, and monitored to support performance improvement when targets or expected results are not achieved.
7. Outlines how and when performance results will be communicated to persons served, family/support, staff, contractors, volunteers, and a variety of stakeholders.

Measurement of program goals in domains identified in the CARF Manual, systematic data collection, monitoring, and evaluation of results will ensure ACR Health Services and services provided by ACR Health Services are accountable for results. Domains of performance improvement include:

1. Program service delivery (effectiveness and efficiency).
2. Business functions.
3. Access to program services by persons served.
4. Customer satisfaction of persons served.
5. Satisfaction of stakeholders.

Performance measurement, management, and improvement will be accomplished through leadership engagement and accountability. The following include leadership's areas of focus:

1. Oversight for effective communication about the PMMP annual results to persons served and other stakeholders.

2. Demonstration of the value of services to persons served, family/support, staff, contractors, volunteers, and other stakeholders.
3. The use of results gathered though the implementation of the PMMP includes evidence-based support for leadership's decision-making.
4. Improvement of the efficiency, effectiveness, satisfaction with, access to, and the quality of services delivery and business functions.
5. Review, uphold, or change the Mission as deemed appropriate and as evidence may support.
6. Allocation of technology and other resources to support implementation of the PMMP.

Scope of the Performance Measurement and Management Plan

The PMMP for services provided by ACR Health Services guides the monitoring, evaluation, and improvement of the effectiveness of services, the efficiency of services, access to services and stakeholder satisfaction. Information will also be gathered on the characteristics of persons served. Persons served and stakeholders will provide input to the plan and will engage in the performance improvement process. Their feedback will guide the selection of goals, indicators, and measures by their sharing of what they want to know about the organization and programs. The plan will be reviewed and updated annually or more frequently as needed.

Definitions

1. Effectiveness – results achieved and outcomes observed for the persons served.
2. Stakeholder/Customer satisfaction – feedback obtained from persons served and other stakeholders about their experience and satisfaction with the program and services.
3. Efficiency – resources used to achieve results for persons served.
4. Service access – the program's ability and capacity to provide services to persons looking for or in need of services.

Roles and Responsibilities

The PMMP focuses on key high priority service and business activities. Improving performance and quality of services is a job function of all staff and contractors of ACR Health Services.

1. Chief Executive Officer: The CEO sets the organization's strategic direction and vision and ensures organizational commitment to performance improvement and the PMMP. The CEO serves on the Performance Improvement Team, ensures implementation of the PMMP; oversee Strategic Planning and performance improvement action plans as related to results achieved; and updating the leadership team regarding PMMP monitoring and results. The CEO creates and distributes the Performance Improvement Team agenda and facilitate its quarterly meetings. The CEO also provides oversight for, and/or facilitates establishing high priority PMMP performance goals, particularly those related to business functions; the availability of resources and technology to support data collection and the analysis of results; reporting of results to all stakeholders; and ongoing compliance with CARF accreditation standards.

2. **PMMP Team:**
   a. Consists of ACR's Leadership Team:
      CEO/Executive Director

Director of Quality Assurance and Compliance
Clinical Director
ACT Team Leader
Director, Housing Support Services
Director, Specialty Programs
Utilization Manager
Practice Administrator

b. Performs tasks and functions that help to ensure the successful development, implementation, and annual review of the PMMP. Analyzes persons served characteristics, and all stakeholder input related to setting up indicators. Identifies comparison information, as available, to establish targets for indicators. Provides the information needed to establish high priority goals for business functions which will be evaluated in the annual PMMP. Identifies factors that may impact results achieved. Responsible for sharing the PMMP results with leadership.

c. Tasks include plan development and annual review; implementation of plan; the collection of complete, valid and reliable data; data analysis; and reporting of results. The PMMP Team will provide oversight of case record review and billing verification processes. The PMMP Team will engage in and support staff training and competencies on the PMMP and implementation.

d. The Team meets quarterly. CEO will be sent a copy of meeting minutes within two weeks of each meeting. An annual written report on the PMMP results, the review of the annual PMMP, along with recommendations and suggestions will be sent to the CEO within 60 days of the close of data collection resulting from the annual plan implementation. The PMMP Team ensures communication of results to staff, contractors, volunteers, persons served, and other stakeholders. Team members will be given training related to their roles and responsibilities for PMMP. Training will be documented.

3. **Leadership Team:** The Leadership Team/ PMMP Team meets monthly or more often if deemed necessary. They review PMMP activities and any other information which affects service delivery and business performance. This may include program information such as: case record reviews, critical incidents, health and safety plan results, accessibility barriers, inclusion opportunities, access to services by persons served, clinical issues, billing issues, and other financial results or concerns. The Leadership Team supports the CEO who ensures the development and implementation of the PMMP and other written organization and program plans. Decisions about information resulting from plan implementation will be made using leadership's decision-making processes.

4. **Staff and Contractors:** Staff and contractors will take part in the PMMP by engaging in applicable documented training and competencies, sharing their expertise, and ensuring that their documentation, which supports data collection, is accurate and complete. Staff will be given training at least annually on their roles and responsibilities for supporting and implementing the PMMP. Training is documented.

5. **Human Resources:** Responsible for data collection from staff and contractors which may include satisfaction and input on workforce and workplace issues.

Data Validity, Reliability, Completeness and Accuracy
ACR Health Services engages in a data driven performance measurement, management, and improvement based upon analysis of valid, reliable, complete, and accurate data.

1. **Valid/validity:** Goals addressed in the PMMP are high priority and will identify what services provided by ACR Health Services hopes to achieve. Valid indicators and measures, tools, surveys, and data collected will measure what they are intended to measure. Results will reflect how service delivery and business processes are doing as compared to the targets or expected results documented in the PMMP. The PMMP Team will annually verify the validity of indicators and data collected for performance measurement purposes by asking the questions, "Are we measuring what we claim to be measuring?" When problems with validity are noted, the PMMP Team acts to ensure resolution.

2. **Reliable/Reliability:** Data will be collected consistently in a manner that is reproducible over time and/or different data collectors. Reliability will be addressed through documented staff and contractor training and competencies. Data reliability will be tested at least annually by:
    a. Comparison of results against internal analyses (for example, historical results comparisons, or comparison of results between multiple program locations that are analyzed separately).
    b. Comparison of results against external results when available.
    c. Monitoring when unexpected or unexplained shifts are noted in performance results.
    d. Monitoring and evaluating data collection staff, collection methods, and data collection sources on a routine basis.

3. **Completeness:** There should be no gaps or missing information from the data set. For example:
    a. Each data field will contain recorded information.
    b. All groups and populations served by the program will be included in the data set.
    c. All program locations will be included under the PMMP and covered in the data set.
    d. Information for all persons served during the reporting period will be available for the data set.
4. Data will be recorded properly and information will be true, correct, and free from errors. This will be achieved through documented staff/contractor training on data recording and providing staff feedback when data entry problems are identified. Concurrent reviews of records of the persons served will be done to ensure correct entry into the database. When necessary and possible, data may be checked against other information available in the record of the person served.

Goals, Indicators and Measures

Goals are statements of what you hope to achieve and are written in the PMMP and Annual Review documents.

Indicators are statements in the written PMMP and Annual Review documents and are linked to a specific goal. Indicators are established in a manner that allows for the program to calculate results in percentages. Indicators typically reflect the rate of change over time.

Measures are also statements found in the written PMMP and Annual Review documents. Instead of quantifying results using percentages, a measure is quantified in units or numbers.

Data Tools and Collection

Data will be collected using various approaches and applications. Tools and applications that support data collection will be identified, recorded in the plan, and reviewed annually for applicability to the PMMP. Staff and contractors will be trained at hire, and refresher trainings will be provided at least annually to assure completeness, accuracy, and reliability of data collection and data entry, and for scoring test results (when applicable). All staff training and competencies related to documentation and collecting data will be documented.

1. Standardized surveys, published assessments, and other tools that have been developed for ACR Health Services will be used for data collection. The data will be collected annually. Measurement tools will include:
    a. Audits/Reviews conducted by external organizations: Reports with scores for critical functions are provided and are available to the PMMP.
    b. Billing Data: Data entered by Billing Coordinator and reports are generated from Electronic Medical Record (EMR)
    c. Client and Employee Surveys: Surveys are conducted by Quality Assurance/Compliance Director, results analyzed and provided to the PMMP.
    d. Client Outcomes - Clinical staff and contractors enter data. Program Manager has oversight. PMMP Team members will obtain or have access to the data set for analysis.
    e. Data is often collected through internal program and business systems. Collecting data for external reporting to payers or licensure requirement is also common. These systems and applications provide data that is available for analysis. Data is collected annually by Quality Assurance/Compliance Director, results analyzed and provided to the PMMP.

2. Information includes:
    a. Program Financial Information – Business office staff enter data and/or confirm data entry. CEO has oversight. PMMP Team members will collect applicable results from the CEO.
    b. Access to Services Information - Clinical staff and contractors enter data. Program Manager has oversight. Intake Coordinators will provide the to the PMMP.
    c. Resource Allocation - CEO enter data into the organization's financial systems. The CEO has oversight of data collection and provide applicable data to PMMP Team members.
    d. Risk Management Plan – Critical incidents are documented by staff. Client complaints and grievances are documented by persons served, family/support, or staff. Quality Assurance/Compliance Director has oversight of data collection for critical incidents, grievances, and complaints. Quality Assurance/Compliance Director will provide applicable results to PMMP Team members.
    e. Human Resource Department tracks workforce relevant data. Examples include hiring, annual staff turnover reports, and Staff/Contractor Satisfaction surveys. – Data is collected by HR staff. The Human Resource Director has oversight. PMMP Team

members will collect PMMP applicable data and results from the Human Resource Director.

f. Health & Safety Committee tracks drills, inspections, and other health and safety events are recorded by Health & Safety Committee members. - The Safety Officer has oversight. PMMP Team members will collect PMMP applicable data and results from Safety Officer.

g. Strategic Plan Results – The CEO has oversight of this plan development, implementation, and documentation of results. Responsibilities are delegated by the CEO. PMMP Team members will collect PMMP applicable data and results from the CEO.

h. Service Delivery Data - Clinical staff and contractors collect data on persons served and enter into the person's record or the appropriate data collection system. Program Manager has oversight. PMMP Team members will obtain or have access to data set for analysis as applicable to PMMP.

i. Incident Reports – The Quality Assurance/Compliance Director has oversight of data collection for critical incidents. Critical incidents are documented by staff. PMMP Team members will collect PMMP applicable results from the Quality Assurance/Compliance Director.

3. Customer satisfaction and input are collected from persons served, staff, contractors, and other stakeholders using a variety of mechanisms.

    a. For over 5 years ACR Health Services has used an internally developed survey tool to measure the satisfaction of persons served and to obtain their input on program services. This include asking in the survey what the person would like to know about the organization and its programs. Performance goals related to customer satisfaction will be identified in this annual PMMP plan. The Quality Assurance/Compliance Director is responsible for oversight of data collection. Based on the preference of the person served, data is collected by phone call from the program, or through emailed distribution of a survey with their return of response by email. The scheduling staff are responsible for data collection. The Program Directors/Leaders is responsible for oversight of the ongoing distribution and collection of stakeholder surveys. PMMP Team members will collect applicable data and results from the Program Manager/Leader.

    b. An annual staff and contractor satisfaction survey will be performed in July using ACR's staff survey tool). The Quality Assurance/Compliance Director will provide oversight for this survey process. Results will be shared with the Leadership Team, within 60 days of completing the survey process. Results shared will be based on the PMMP annual established indicators.

4. External Audit Reports are routinely received annually from various payers including Medicaid Health Plans, third-party insurance carriers, regulatory, certification, and accrediting bodies. Data and opportunities for PMMP goals may found in these reports.

5. Other written plan results for ACR Health Services may be a resource for performance measurement and management opportunities. These include the accessibility plan; the cultural competency, diversity, and inclusion plan; the strategic plan; the risk management plan; and the technology and system plan.

Identification of Service Gaps and Opportunities
In addition to collecting customer satisfaction and stakeholder input, ACR Health Services collects demographic, characteristic, and other information for each person served. This information and input obtained from persons served and other stakeholders will be used to identify service gaps and opportunities, explain results obtained, and support the development of PMMP goals.

Data collection about persons served is overseen by the Program Director/Leader. It occurs:

1. At the beginning of services on first visit/admission by Intake Assessor.
2. Appropriate intervals during services upon reauthorization for services (typically 90 or 180-days dependent on program by Therapist and/or Case Manager.
3. At the end of services (at time of transition or discharge) by Therapist and/or Case Manager.
4. At point(s) in time following services (30 days after discharge) by Therapist and/or Case Manager).

The same information will be collected from all individuals who participant in programs provided by ACR Health Services, and includes the following: age ethnicity, race, primary language, post discharge status, etc.

Data Analysis and Results
Data analysis will be performed by The Quality Assurance/Compliance Director, who is a member of the PMMP Team, and has the technical skills to analyze ACR Health Services' data sets. The following activities will occur in relation to data analysis:

1. To obtain a clean data set, data errors, redundancy, and irrelevant information will be corrected or removed.
2. Every program location will be included in the analysis.
3. Calculations will be performed on the clean data set. This will include the use of applications such as Excel.
4. Results will be compared to the targets or expected results that have been documented in the PMMP.
5. Extenuating circumstances and influencing factors that may have an impact on the results will be documented.
6. Results of data analysis will be documented.
7. Results will be presented using written narrative, tables, and graphs. Results will be communicated based on the needs of the specific group, including content, format, and timing.
8. Performance results will be communicated by a written and verbal presentation to the PMMP Team within 90 days of the close of the PMMP each year.

PMMP Annual Review

The Performance Measurement & Management Plan will be reviewed by the PMMP Team at least annually. The review will occur *within 14 days of the written performance results being presented to the PMMP Team*. This review will document any changes that are needed for the next PMMP annual plan. The review includes:

1. Ensuring the accuracy of the plan's description of the: program services; PMMP Team and Advisory Committee membership; roles and responsibilities related to the plan; and the reporting structure for PMMP activities, annual review, and results. Time frames in the prior plan will also be reviewed to ensure that they are achievable.
2. The efficacy of performance indicators will be reviewed.
3. Goals, indicators, and targets that will be carried over to the next annual PMMP will be documented. New goals, indicators, and expected results will be added based on the review of stakeholder input, satisfaction, and other feedback; other organization and program plans; and any other internal and external information which the PMMP Team reviews and identifies as a high priority performance improvement opportunity. Service and business function goals for the PMMP will be reviewed by leadership who may add high priority goals to the PMMP, especially goals related to business functions.
5. The results for each performance indicator will be reviewed and corrective action plans will be developed when expected results are not achieved. Corrective action plans may be needed to improve the program's services, business functions, and the performance monitoring plan. Corrective action plans will include strategies for change, resources needed, roles and responsibilities, expected results, strategy implementation, data collection methods, and time frames. Future results will show if a corrective action plan has been effective. Reaching or exceeding a target or established target helps to ensure that suboptimal performance results do not reoccur in the future.
6. The PMMP annual report and the associated correction plans, as well as the updated PMMP annual plan will be sent to the CEO within 90 days of the close of the PMMP year.

2022 Performance Goals, Indicators, and Measurement

The collection of data and subsequent analysis are used to evaluate and monitor *services provided by ACR Health Services* business functions, access to services, and service delivery. Data is collected to include relevant characteristics of persons served. Data is also collected from persons served and stakeholders on their experiences/satisfaction with program services and their input on what they would like to know about the organization and programs. This data is used to support development of goals and indicators, and to help analyze results achieved.
Performance indicators or measures are developed to address goals in those areas established by CARF including:

1. The effectiveness of services (addressing the quality of care and service outcomes).
2. The efficiency of services (resources used to achieve results for persons served).
3. Service access.
4. Business functions.
5. Persons served satisfaction and experience with services.
6. Stakeholder satisfaction and experience with services.

To measure ACR's effectiveness of services, efficiency of services, service access, stakeholder satisfaction and feedback, the 2022 plan will establish for each of these areas:

1. At least one objective or goal for each area identified.

2. To whom the measure or indicator will apply.
3. The person(s) responsible for data collection.
4. The sources for the data collection.
5. Time frames for collection of data.
6. A performance target or expected result is based on any of the following:
    a. The organization/program history.
    b. Established by the organization or a stakeholder such as a payer.
    c. Based on industry comparisons or benchmarks.
7. Extenuating and influencing factors that may impact results.

ACR Health Services 2022 PMMP will be implemented on January 1, 2022 with data collection completed on December 31, 2022.

	Objective Domain	Objective	Indicator	Target	To Whom Applied/ Obtained By	Time of Measure	Data Source	Result
Internal Business Process Focus	**Financial**	Limit Billing Write-Offs	Number of Progress Notes Written Off	=<2% of all notes submitted	All programs/collected by Utilization Manager Monthly	Monthly	ShareNote Billing Report – Notes of Workflow	
	Financial	Accurate Billing	Billing Validation Score	=> 90%	All Programs that Bill Medicaid/ ASO Reviewers	Annually or as determined by ASO	ASO Behavioral Health Quality Review (Review Date: 6/28/2021	
	Efficiency	Direct service per week	Hours of direct staff service hours per week	90% of billable hour requirement	All direct service staff	Monthly	ShareNote Billing Report	
Participant & Stakeholder Focus	**Effectiveness Adult Behavioral Health**	Improve functioning	Scores on the Adult Needs and Strengths Assessment (ANSA) Rating Scale	3/5	All Adult Core and ACT / therapist	Quarterly	Therapist ANSA evaluation	
	Effectiveness Assertive Community Treatment ACT)	Improve functioning	Scores on the Adult Needs and Strengths Assessment (ANSA) Rating Scale	3/5	All Adult Core and ACT / therapist	Quarterly	Therapist ANSA evaluation	
	Effectiveness Child and Adolescent Behavioral Health	Improve functioning	Scores on the Child and Adolescent Needs and Strengths (CANS) Rating Scale	3/5	All C&A / therapist	Quarterly	Therapist ANSA evaluation	
	Effectiveness Peer Center	Improve functioning	Scores on the Participant Survey	4/5	All Peer Center participants/ collected by Peer Center Team	Quarterly	Self-report survey	
	Effectiveness AOD Program	Reduction in drug use	Drinking/drug days/30 days	3/5	All AOD clients/collected by case manager	Quarterly	Self-report survey	
	Access	Reduce time from request to intake	# Hours from request to intake	Within 24 hrs	All Program Participants/collected by case manager	Daily	EHR date stamp	
	Satisfaction	Increase client satisfaction	% Clients satisfied with services received	4/5	All Program Participants/collected by case manager	Quarterly	Self-report survey	
Learning & Growth Focus	**Accuracy of DBHDD Programs/Services**	Increase the provision of services IAW with payer guidelines	Compliance with Service Guidelines	=>90%	All DBHDD Programs/services	Annually or as determined by ASO	ASO Behavioral Health Quality Review (Review Date: 6/28/2021)	
	Effectiveness DBHDD Programs/Services	Ensure services provided matches recovery needs	Assessment & Planning	=>90%	All DBHDD Programs/services	Annually or as determined by ASO	ASO Behavioral Health Quality Review (Review Date: 6/28/2021)	
	Effectiveness Assertive Community Treatment (ACT)	Improve functioning	Scores on Annual Dartmouth ACT Fidelity Scale (DACTS) Review	Total Mean Score => 4.0 Total DACTS Score => 112 (established by DBHDD)	ACT Program / DBHDD ACT & CST Services Unit	Annually	Dartmouth ACT Fidelity Scale (DACTS) (Review Date: 2/25/2021)	

Communication of Results

ACR Health Services will communicate accurate performance information to persons served, staff, and other stakeholders using a format and language that is understood by each constituency. This includes tailoring the content, format, and timing of release of information based on the needs of each specific group. The following is the outline of our plan to communicate PMMP results to our targeted audiences.

Audience	Communication channel(s)	Time frame for PI Information Release	Responsible Staff	Content
CEO & Leadership Team.	1. Written report. 2. Presentation at Leadership meeting.	Before the end of the 1st Quarter of 2023 these tasks will be completed.	Quality Assurance/Compliance Director.	All results.
Program Staff.	1. Presentation at team meetings. 2. Post in staff areas. 3. Share report through staff email.	Before the end of the 1st Quarter of 2023 these tasks will be completed.	Directors/Team Leaders	All results. (Also, will share the new PMMP).
Advisory Board.	Annual Report for Organization. Annual meeting which includes Board and Staff.	By the end of 1st Quarter of 2023 these tasks will be completed.	CEcx.	Highlights of all results.
Persons Served.	1. Handbook distributed at program orientation. 2. Posted in treatment areas and lobby. 3. Posted on website.	Handbook update by April 15, 2023. Distributed copy to each person served at orientation to program. Posting in facility and on website by April 15, 2023.	Clinic Directo4 Website update by Technology Consultant	Results Participant & Stakeholder Focus.
Community Partners Referral Payer Sources.	1. Email to partner CEOs. 2. Marketing visits or phone calls by Leadership Team to partner peers. 3. Website.	Emails sent and website posting by April 15, 2023. "Marketing" visits or calls throughout the year - at least 2 monthly.	Director of Marketing. Website update by Technology Team.	Highlights of all results.

Policy 15.02 - Clinical Record Reviews

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to routinely conduct clinical record reviews to assure all required documentation is complete, current and correct, as well as to monitor the quality and utilization of services.

II. PROCEDURES:

A. Quality Improvement staff reviews records in each program regularly. These reviews are conducted as follows:

   a. A sample of records will be reviewed in each program. The sample will be selected at random by the reviewer.

   b. Reviews are conducted on site at each of the locations that house medical records. At least one record from each provider from that site will be reviewed.

   c. Records of both active and discharged consumers are reviewed. The reviewer will review the records using established tools which capture agency requirements as well as licensure, human rights and third party requirements.

B. In addition to reviews that are routine in nature, reviews may also be conducted at established intervals and/or with a specific focus. Examples of focused reviews include reviews prior to consumers being discharged from a program/service, when a consumer changes programs, eligibility for program, prior to staff leaving agency, etc.

C. Reports from these scheduled and unscheduled reviews are forwarded to Program Managers, Division Directors, and the Quality Improvement Director. These reports are utilized by management staff for supervision and management purposes. Reports are also reviewed in a systemic vein to determine whether any program- or agency-wide issues need to be addressed.

D. QI staff conducts follow-up reviews to ensure that corrections have been made, where appropriate.

E. In addition to reviews conducted by QI staff, program supervisors review consumer records for many of the same elements. In some programs, peer reviews are conducted as well.

Policy 15.03 - Clinical Documentation Auditing Procedures

I. POLICY:

Assertive Community Recovery, LLC (ACR) will conduct regular internal audits of billing and clinical documentation, required clinical assessments and treatment plans, and compliance with HIPAA privacy regulations to ensure that the agency is pursuing the highest level of professional best practice, routine sampling audits are conducted to assist agency personnel achieve optimum performance. As a by-product of this practice, the implementation of a check and balance system provides assurance against waste, fraud and abuse. Internal audit of billing against clinical documentation is designed to conform to the best practices as identified by regulatory agencies.

II. PROCEDURES:

The following procedures shall be used to conduct internal audits:

A. **Auditing Schedule:** Audits by the Quality Assurance Program Manager in conjunction with the Utilization Management Coordinator, shall be conducted quarterly. The quarterly audit schedule shall be determined by the Quality Assurance Program Manager. Also, site / program supervisors may request a special audit of particular cases.

B. **Sample Selection:** The selection of a sample of open and closed cases for documentation auditing shall be determined by the auditor. The cases selected for audit may be proportionately representative of the consumer population by program and by payment method (Medicaid and others. Audit samples will be no less that 25% of annual consumers served each quarter, including both UM and manager audits with the intent that each consumer chart will be audited annually.

C. **Audit Forms and Records:** The audit forms used shall be determined by the Quality Assurance Program Manager, and approved by the Management Team prior to each Fiscal year. The Sharenote Qualitative Service Review (QSR) will be used to document audit results.

D. The Quality Assurance Program Manager will approve a glossary of expanded definitions and explanations of how items in the audit form are to be interpreted and scored.

E. HIPAA audits will assess overall site compliance with privacy and information security regulations in addition to evidence in consumer charts that privacy policies have been followed at intake, and when protected health information is disclosed.

F. Originals of individual audit checklists and summary reports shall be retained in the Quality Assurance Audit file for a period of 5 years, after which they will be destroyed.

An electronic record (with off-site backup) shall be considered as acceptable as a paper record.

G. **Personnel Assigned:** Audits shall be conducted by the Quality Assurance Program Manager or other designated personnel with the approval of the Quality Assurance Program Manager.

H. Corrective Action Mechanisms

1. Quality Assurance Program Manager will require a corrective action plan from the appropriate managers/supervisor in all cases in which agreed deficiencies have been identified. If an item cannot be corrected, this is to be noted on the checklist as well as use the findings to provide clinical guidance to staff they supervise
2. A copy of the chart audit tool is also submitted to the medical director for review of the MD documentation results. The Medical Director is to use the audit results to provide clinical supervision and guidance to the MD under his supervision.
3. Program managers must document specific efforts performed/planned to bring site into compliance (if planned must include date and person responsible) and must be accompanied with documented training/meeting minutes and sign-in sheets.
4. All corrective action plans must be returned to the Quality Assurance Program Manager within 30 days of receipt of the audit results. At least 10% of all corrective action plans will be reviewed at next quarterly audit for compliance.

I. **Training Needs :** Audit tools should be utilized by program manager to identify clinician's/sites weak and strong areas to determine training. Program managers should utilize the corrective tool to address the training needs for each indicator listed (if not meeting compliance level). Quality Assurance Program Manager will provide training at a minimum of a quarterly basis on identified needs. All corrective tools will be reviewed at Management Team Meetings.

J. **Audit Report:** Quality Assurance Program Manager shall compile a summary quarterly showing documentation (and peer review) audit results by program and for ACR as a whole (as an element within the ACR Balanced Scorecard). The summary report will be distributed to the CEO/Executive Director, the Medical Director, Clinical Director and Program Managers and Team Leaders.

Attached Sharenote Qualitative Service Review (QSR) Instructions:

Policy 15.04 - Utilization Review Quality Assurance/Quality Improvement Program

I. POLICY:

The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Medical services and/or records are reviewed to monitors and evaluate the clinical necessity, appropriateness and efficiency of behavioral health-care services, procedures or level of care. The overall goal of the review process is to coordinate the services to promote health and wellness, and to maximize independence and resources to support clients and members in their recovery.

II. PROCEDURES:

A. ACR's Utilization Manager(UM) is responsible for the review and evaluation of medical records for accuracy and appropriateness of clinical documentation and quality of care; to ensure all activities conform with Federal and State regulations and local requirements; to provide narrative and statistical analyses of audits; and to perform related work as required.

B. The UM discusses discrepancies in documentation of services with appropriate clinical and administrative staff and recommends actions to resolve issues.

C. Compares medical record documentation with professional standards of care outlined in the DBHDD Providers Manual, Medicaid Documentation Standards and in accordance with Federal, State regulations and other regulatory guidelines.

D. Reviews request for services to ensure that all the medical necessity of requested services is clearly documented in the assessment of the consumer prior to requesting authorization for service from the Medicaid organization.

E. Coordinates timely reviews of treatment plans and services provided by the clinical staff. ACR Treatment Plan Review Form is used document this review.

F. The UM Organizes, monitors, and audits activities.

G. Writes statistical and narrative reports on outcome of audits of service delivery, highlighting areas such as timeliness of documentation, over- and under-utilization of service units, appropriateness of service provided as indicated from assessments, certified admissions and extensions, and administrative stays.

H. Develops and findings from audits and recommends corrective action in accordance with Federal and State regulations.

I. Provides in-service education ACR staff regarding quality management documentation and service utilization.

Policy 21.01 - Behavior Health Programs

PURPOSE

To provide guidance in establishing practice that effectively operationalizes and supports a "team" approach for all adult behavioral health recipients that focuses on recovery and implements plans that are outcome based and is consistent with Georgia's Principles of Person-Centered Planning and requirements for service delivery as propagated by the Department of Behavioral Health and Developmental Disabilities (DBHDD).

TARGET POPULATLION

Medicaid recipients living in the metropolitan region of Atlanta eighteen years or older or emancipated minors in need of mental or behavioral health support services and with/without substance abuse concerns as specified by The Department of Behavioral Health & Developmental Disabilities. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.

INTRODUCTION

The following items are key concepts in team-based service planning:

•**Strength and Needs-Based Planning.** Based on the initial and ongoing strength-based assessment, all services should be customized to creatively reflect the person's unique culture and individual and familial strengths in addressing the person's behavioral health needs.

•**Consensus.** All teams strive to reach consensus regarding the needs of the person, the findings of the assessment process and the service plan.

•**Natural and Informal Supports**. Although team membership will vary with changing needs and developing strengths, teams are encouraged to strive toward memberships that include natural and informal supports.

•**Collaboration.** Collaboration should be sought from other involved family members, agencies and the community at-large.' The team should strive to promote connections with all .the community has to offer rather than, for example, relying solely on paid supports.

•**Crisis Stabilization and Crisis Planning.** The team should identify and develop strategies to resolve urgent health, safety and security needs. In addition, the team should assist the person in developing a plan that includes strategies intended to prevent or mitigate crisis situations. Crisis planning seeks only to stabilize the crisis, not to change the overall plan, and incorporates family, friends, natural supports, and formal supports if necessary.

•**Cultural Competency.** The adult team process, from the assessment to the facilitation of team meetings and the provision of services, should be culturally competent and linguistically appropriate, and based upon the unique values, preferences and strengths of the person, involved family members, and the community.

BACKGROUND

The following Principles of Person-Centered Planning are required for behavioral health assessment and service planning.

- Services are developed with the understanding that the system has an unconditional commitment to its individuals.
- Services begin with emphatic relationships that foster ongoing partnerships, expected equality and respect throughout the service delivery.
- Services are developed collaboratively to engage and empower individuals, include other individuals involved in the individual's life, include meaningful choice, and are accepted by the individual.
- Services are individualized, strength-based and clinically sound, and
- Services are developed with the expectation that the individual is capable of positive change, growth and leading a life of value.

DEFINITIONS

Adult Clinical Team: A group of individuals working on collaboration who are actively involved in a person's assessment, service planning and service delivery. At a minimum, the team consists of the person, their guardian (if applicable) and a qualified behavioral health representative. The Team may also include members of the enrolled person's family, physical health providers, mental health or social service providers, representatives of other agencies serving the person, professionals representing disciplines related to the person's needs, or other persons identified by the enrolled person.

Diagnostic and Statistical Manual of Mental Disorders, (DSM):. Better known as the DSM, the manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis as well as some research concerning the optimal treatment approaches.

Empowerment: An intentional, dynamic, ongoing process involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources.

Engagement: The establishment of a trusting relationship, rapport and therapeutic alliance based on personal attributes, including empathy, respect, genuineness and warmth.

Family: The primary care-giving unit, inclusive of the wide diversity of primary care-giving units in our culture. Family therefore is a biological, adoptive or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children.

Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are also included in the definition of family.

Family Member: A spouse, parent, adult child, adult sibling or other blood relative of a person undergoing treatment, evaluation, or receiving community services.

Guardian: An individual or entity appointed by an appropriate court or legal authority to be responsible for the treatment or care of an individual.

Interim and Ongoing Individual Service Plans: A written description of the behavioral health services and other informational supports that have been identified through the assessment and treatment planning process that address immediate needs and assist the person to meet his/her specified goals.

Natural and Community Supports: Those social connections, organizations, services and affiliations that are available in the community to all community members that can serve as a social network, safety net and resource for activities, education, support and leisure. Supports can include family members, neighbors, churches, sports teams, clubs, etc.

Recovery: An ongoing dynamic interactional process that occurs between a person's strengths, vulnerabilities, resources, and the environment. It involves a personal journey of actively self-managing psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, roles, and life beyond the mental health system, in spite of the challenge of psychiatric disability. Recovery involves learning to approach each day's challenges, to overcome disabilities, to live independently, and to contribute to society. Recovery is supported by a foundation based on hope, belief, personal power, respect, connections, and self-determination.

Recovery Goal: Describes where the person wants to be and how they will know when a service is no longer needed. Provides a vision of how the person would like their life, family and environment.

Stigma: A cluster of negative attitudes and benefits that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma leads to low self-esteem, isolation, and hopelessness in individuals, and deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems often internalize public attitudes and become so embarrassed or ashamed that they conceal symptoms and fail to seek treatment.

Evidenced Based Planning and Treatment: The standard for all treatment implemented by ACR. Evidenced Based Planning and Treatment is distinguished by:

- using the best scientific evidence
- individualizing the evidence for the unique needs and preferences of each person
- a commitment to the ongoing expansion of evidenced and clinical expertise.

21.01 - Behavior Health Programs

ACR's Treatment Focus:

Recovery for individuals suffering from mental and behavior health problems is primary goal for all treatment programs develop by ACR. We will assist individuals and as appropriate, their families in determining their individual goals to live, work, learn, and participate fully in their communities. We recognize that individuals have the inherent right to determine the quality and nature of their individual recovery journey; for some it may be the ability to live a fulfilling and productive life despite a disability and for others recovery implies the reduction or complete remission of symptoms. Evidenced based practices will be used in the development of all treatment services. Key to all of services is instilling hope, which is supported by scientific evidence has shown that having hope plays an integral role in an individual's recovery. Guiding principles of ACR's service delivery programs are:

1. Services and treatments are participant and family-centered, set to provide individuals real and meaningful choices about their treatment options.

2. Care must focus on increasing participants' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

Out of the six goals put forth by the Commission to transform the mental health system of care, Goal Two is the one that addresses the issues related to individual planning for services. Simply stated, the report calls for mental health care that is participant and family-driven.

ACR Clinical Teams:

Currently ACR has the following Clinical Teams; each headed by mental health professional.

- Assertive Community Treatment
- Brief Stabilization and Core Recovery Program (Adult & Child and Adolescdent)
- Peer Supports
- Housing Support Program

WHAT ARE THE RESPONSIBILITIES OF THE TEAM?

The team's primary function is to develop a comprehensive and unified service plan with the enrolled person that is responsive to his/her identified needs. The team uses a person-centered approach that:

- Explores and documents the strengths and needs of the person;
- Establishes and prioritizes service goals;
- Identifies the supports necessary to meet those goals;
- Describes a course of action encompassed in a written plan within 90 days of the intake developed by team members;
- Monitors and recognizes accomplishments;
- Determines the responsibilities of all team members in these efforts; • Continually updates assessment; and
- Reviews and revises the service plan as needed

WHO SHOULD PARTICIPATE IN THE TEAM:

At a minimum, the team consists of the person and a qualified behavioral health representative. In general, the size, scope and/or intensity of involvement of the team members are determined by the acuity and intensity of the service needs, objectives established by the person, and the individuals that are needed to develop and coordinate an effective service plan. Therefore, the team's composition will expand and contract as necessary to be successful on behalf of the person. For example, based on the individual's needs, the team for a person determined to have a serious mental illness might include a psychiatrist, case manager, vocational specialist, nurse, and other professionals or paraprofessionals such as service providers (e.g., counselors, residential staff, peer -support workers) or a health plan representative. While the Clinical Liaison or behavioral health representative should be a consistent participant, other team members may only attend planning sessions as needed.

TREATMENT PLANNING:

ACR will develop Individualized Recovery Plan (IRP) with the input of participants and (if appropriate) their identified families input which is reviewed and updated every 30 days or more often if necessary. The IRP will be developed from the goals of the individual. Areas to considered in IRP development are:

a) Identification of barriers that impede the development of skills necessary for independent functioning in the community
b) Strengths assessment
c) Identify the support need to facilitate recovery
d) Linkage with community agencies
e) Family counseling/training for individuals and their families
f) Physical health symptom monitoring and illness self-management skills
g) Financial management skill development;
h) Personal development and school/work performance;
i) Substance abuse counseling and intervention
j) Psychosocial rehabilitation and skill development
k) Psychoeducational and instrumental support to individuals and their identified family

All IRPs will consider the support that individuals and their families may need in a crisis and interventions needed to assist when needed.

ASSESSMENT

Key to all ACR programs and service delivery is assessment. All individuals served will be provided the following assessments:

Brief Assessment: within the first 7 days of service - to determine immediate needs, eligibility for services, elevate risk of harm and identify any crisis. Also a determination is made if participant needs immediate referral for on-going services or if the Brief Period should be used in an attempt to stabilize participant, resolve the immediate crisis and conduct more in-depth assessments to determine true treatment need and confirm diagnosis.

Within 30 days of service onset the following assessments will be conducted:

BioPsychoSocial Assessment: A face-to-face comprehensive clinical assessment with the individual, that includes the individual's perspective, and may also include participant-identified family and/or significant others as well as interviews with collateral agencies/treatment providers (including Certified Peer Specialists who have been working with participants on goal discovery) and other relevant individuals. The purpose of the assessment process is to determine the individual's problems, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to develop or review collateral assessment information. The information gathered supports the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders. As indicated, information from medical, nursing, peer, vocational, nutritional, etc. staff serves as the basis for the comprehensive assessment and the resulting IRP. The entire process should involve the individual.

Psychiatric assessment: A face to face interview with the psychiatrist includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis);screening and/or assessment of any withdrawal symptoms for individuals with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. May include communication with family and other sources, as well as the ordering and medical interpretation of laboratory or other medical diagnostic studies.

Nursing Assessment: A face to face interview with an registered nurse or licensed professional nurse to identify the physical, nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of an individual's treatment and develop interventions to assist individuals manage their whole wellness (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc).

Other Assessments will be conducted as needed on a case-by-case basis:

- Client's Assessment of Strengths, Interests and Goals (CASIG)
- Psychological Assessment
- Vocational Assessment
- Substance Abuse Assessment

It is ACR's goal that all individuals that enter our programs will be accessed and the need for ongoing services be identified within 30 days (maximum of 90 days); and then based on the results of the assessments will be referred to lowest level that will be meet their needs.

Multiculturalism:

Efforts will be made recruit staff so that there is sufficient representation of the local cultural population that the team serves.

All team members will participate in multicultural training within 30 days of hiring.

21.01 - Behavior Health Programs

Staff Qualifications: The current Georgia DBHDD Behavioral Health Policy Manual guidelines for staff qualifications will take precedent at times.

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Physician (M.D., D.O., etc.)	Graduate of medical or osteopathic college	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Psychiatrist (M.D., etc.)	Graduate of medical or osteopathic college and a residency in psychiatry approved by the American Board of Psychiatry and Neurology	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Physician's Assistant (PA)	Completion of a physician's assistant training program approved by the Georgia Composite Board of Medical Examiners -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP staff	Licensed by the Georgia Composite Board of Medical Examiners	Physician delegates functions to PA through Board-approved job description.	43-34-100 to 43-34- 108
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist/Psychiatric Mental Health (CNS-PMH) and Nurse Practitioner (NP)	R.N. and graduation from a post-basic education program for Nurse Practitioners Master's degree or higher in nursing for the CNS/PMH -- Nurse Practitioners must have at least 1 year of experience in behavioral healthcare to supervise CPRP, CPS, or PP staff	Current certification by American Nurses Association, American Nurses Credentialing Center or American Academy of Nurse Practitioners and authorized as an APRN by the Georgia Board of Nursing	Physician delegates advanced practice functions to APRN, CNS-PMH, NP through Board-approved nurse protocol agreements.	43-26-1 to 43-26-13, 360-32
Licensed Pharmacist (LP)	Graduated and received an undergraduate degree from a college or school of pharmacy; completed a Board- approved internship and passed an examination.	Licensed by the Georgia State Board of Pharmacy	No	26-4
Registered Nurse (RN)	Georgia Board of Nursing-approved nursing education program -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP. OR A nursing education program approved by an equivalent board of nursing in a state that is a member of the Enhanced Nursing Licensure Compact (eNLC).	Licensed by the Georgia Board of Nursing OR Licensed as an RN in an Enhanced Nursing Licensure Compact (eNLC)-participating state, and possessing an Enhanced Nursing Licensure Compact license granted by the National Council of State Boards of Nursing (NCSBN). Practice must comply with all NCSBN and Georgia Board of Nursing rules and regulations.	By a physician	43-26-1 to 46-23-13 43-26-60 to 43-26-65
Licensed Practical Nurse (LPN)	Graduation from a nursing education program approved by the Georgia Board of Licensed Practical Nursing. OR Graduation from a nursing education program approved by an equivalent board of nursing in a state that is a	Licensed by Georgia Board of Licensed Practical Nursing OR Licensed as an LPN in an Enhanced Nursing Licensure Compact (eNLC)-participating state, and	By a Physician or RN	43-26-30 to 43-26-43 43-26-60 to 43-26-65

21.01 - Behavior Health Programs

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
	member of the Enhanced Nursing Licensure Compact (eNLC).	possessing an Enhanced Nursing Licensure Compact license granted by the National Council of State Boards of Nursing (NCSBN). Practice must comply with all NCSBN and Georgia Board of Nursing rules and regulations.		
Licensed Dietician (LD)	-Bachelor's degree or higher with a degree in dietetics, human nutrition, food and nutrition, nutrition education or food systems management. Satisfactory completion of at least 900 hours of supervised experience in dietetic practice	Licensed by Georgia Board of Licensed Dieticians	No	43-11A-1 to 43-11A-19
Qualified Medication Aide (QMA)	Completion of a prescribed course conducted by the Georgia Department of Technical and Adult Education and pass examination for qualified medication aides approved by the Georgia Board of Licensed Practical Nursing.	Certified by the Georgia Board of Licensed Practical Nursing	Supervised by RN performing certain medication administration tasks as delegated by RN or LPN.	43-26-50 to 43-26-60
Psychologist (PhD or PsyD)	Doctoral Degree	Licensed by the Georgia Board of Examiners of Psychologists. OR Licensed to practice Psychology in a Psychology Interjurisdictional Compact (PSYPACT)-participating state, and possessing either an E.Passport or Interjurisdictional Practice Certificate (IPC) granted by the Association of State and Provincial Psychology Licensing Boards (ASPPB). Practice must comply with all ASPPB and Georgia Board of Examiners of Psychologists rules and regulations.	No. Additionally, can supervise others	43-39-1 to 43-39-20 43-39-6 43-39-7 43-39-8 43-39-21 43-39-22
Licensed Clinical Social Worker (LCSW)	Master's degree in Social Work plus 3 years of supervised full-time work in the practice of social work after the master's degree.	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Professional Counselor (LPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Marriage and Family Therapist (LMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and	No. Additionally, can supervise others	43-10A

21.01 - Behavior Health Programs

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
		Marriage and Family Therapists		
Licensed Master's Social Worker (LMSW)	Master's degree in Social Work	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional.	43-10A
Associate Professional Counselor (May be noted as LAPC and APC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Associate Marriage and Family Therapist (May be noted as LAMFT and AMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Certified Advanced Alcohol and Drug Counselor (CAADC) Note: ICAADC is an accepted equivalent.	Master's degree or above in human services, with a clinical application. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium /Alcohol and Other Drug Abuse (IC&RC).	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Georgia Certified Alcohol and Drug Counselor Level III (GCADC-III)	Master's degree or above in human services, with a clinical application. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium /Alcohol and Other Drug Abuse (IC&RC).	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Master Addiction Counselor (MAC) through the National Board of Certified Counselors (NBCC)	Master's Degree Documentation of a minimum of 12 semester hours of graduate coursework in the area of OR 500 CE hours specifically in addictions. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the National Board of Certified Counselors (NBCC) Nationally Certified Counselor (NCC) credential – must be Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists.	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Master Addiction Counselor (MAC) through the National Association of Alcohol and Drug Counselors, (NAADAC)	Master's degree or higher in Substance Use Disorders/Addiction and/or counseling related subjects. Current credential or license as a Substance Use Disorder/Addiction Counselor or Professional Counselor issued by a state or credentialing authority. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set	Certification by the National Association of Alcohol & Drug Abuse Counselors, the Association for Addiction Professionals. Current credential or license as a Substance Use Disorder/Addiction Counselor or Professional Counselor issued by a state or credentialing	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7

21.01 - Behavior Health Programs

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
	forth by the certifying body and maintain certification in good standing.	authority.		
Georgia Certified Alcohol and Drug Counselor II (GCADC- II) Note: CADC-II and ICADC-II are accepted equivalents.	Bachelor's degree. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC).	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Certified Addiction Counselor, Level II (CAC-II)	Bachelor's degree. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Georgia Addiction Counselors' Association.	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Georgia Certified Alcohol and Drug Counselor I (GCADC-I) Note: CADC-I and ICADC- I are accepted equivalents.	GED / high school diploma (state accredited) or higher. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC).	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Certified Addiction Counselor, Level I (CAC-I)	GED / high school diploma or higher. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Georgia Addiction Counselors' Association.	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Certified Alcohol and Drug Counselor – Trainee (CADT-T)	High school diploma/equivalent or higher, and actively pursuing certification as a GCADC. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the criteria set forth by the certifying body and maintain certification trainee status in good standing. Completion of Standardized Training Requirement for Paraprofessionals approved by the Georgia Department of Community Health.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC).	Under supervision of a Certified Clinical Supervisor (CCS), MAC, CAADC, CAC- II, GCADC-II or -III, LPC, LCSW or LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific continuing education hours per year. Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Certified Counselor in Training (CCIT)	High school diploma/equivalent or higher, and actively pursuing certification as a CAC. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the criteria set forth by the certifying body and maintain certification trainee status in good standing. Completion of Standardized Training Requirement for Paraprofessionals approved by the Georgia Department of	Certification by the Georgia Addiction Counselors' Association.	Under supervision of a Certified Clinical Supervisor (CCS), MAC, CAADC, CAC- II, GCADC-II or -III, LPC, LCSW or LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific continuing education hours per year. Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency	

21.01 - Behavior Health Programs

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
	Community Health.		treatment.	
Certified Psychiatric Rehabilitation Professional (CPRP)	High school diploma/equivalent, Associates Degree, Bachelor's Degree, Graduate Degree with required experience working in Psychiatric Rehabilitation (varies by level and type of degree)	Certified by the US Psychiatric Rehabilitation Association (USPRA, formerly IASPRS)	Under supervision of an appropriately licensed/credentialed professional	
Certified Peer Specialist (CPS)	High school diploma/equivalent	Certification by the DBHDD through the Georgia Mental Health Participant Network in accordance "DBHDD's Training and Certification of Peer Specialists, 01- 123."	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	
Certified Peer Specialist-Addictive Disease (CPS-AD)	High school diploma/equivalent	Certification by the DBHDD through the Georgia Council on Substance Abuse as a CARES (Certified Addiction Recovery Empowerment Specialist) in accordance with "DBHDD's Training and Certification of Peer Specialists, 01- 123."	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	
Certified Peer Specialist-Whole Health (CPS-WH) (Whole Health & Wellness Coach)	High school diploma/equivalent	Certification by the DBHDD through the Georgia Mental Health Participant Network in accordance with "DBHDD's Training and Certification of Peer Specialists, 01- 123."	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	
Paraprofessional (PP)	Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and online training outlined below.)	Completion of a minimum of 46 hours of paraprofessional training and successful completion of all written exams and competency-based skills demonstrations.	Under supervision of an appropriately licensed/credentialed professional.	
Psychologist / LCSW / LPC / LMFT's supervisee/trainee (S/T)	Must meet the following: Minimum of a bachelor's degree; and Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and online training outlined below); and; one or more of the following: Registered toward attaining an associate or full licensure; and/or In pursuit of a master's degree that would qualify the student to ultimately qualify as a licensed practitioner; and/or Not registered, but is acquiring documented supervision toward full licensure There shall be a signed attestation by the practitioner and supervisor to be on file with personnel office; and The attestation must include the	Under supervision in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	Under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	43-10A

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
	anticipated and/or actual date, degree earned, licensure type (e.g. Psychologist, LCSW, LMFT, LPC), and anticipated date of licensure examination; and The attestation must be updated on an annual basis.			
Vocational Rehabilitation Specialist (VS/PP or PP/VS)	Minimum of one-year verifiable vocational rehabilitation experience.	Employed by a provider that is DBHDD approved to provide ACT.	Under supervision of an ACT team leader who is either a physician, psychologist, PA, APRN, RN with a 4-year BSN, LCSW, LPC, or LMFT.	

Background Checks: Staff will have criminal history records, motor vehicle driving records. education and professional licenses checked and verified during the hiring process.

Training Requirements: Staff (excluding physicians, NPs, and PAs) are required to complete 16 hours of training each year. First-year requirements for clinical staff include human resources orientation and job orientation, organizational philosophy and operating values, continuous quality improvement, cultural competence, medical records, service activity logs, closure/during treatment assessment, clinical orientation (managed care system and provider network, client rights/recovery model, family strengths, psychopathology, motivational interviewing and addictive behaviors, and psychopharmacology), best practices exam, risk management (confidentiality; boundaries, ethics, dual relationships; safety; critical incidents/accidents/medication errors; working with challenging clients), infection control, drug-free workplace, sexual harassment, and policy & procedures review. Supervisors are also required to attend training on documenting discipline, basic wage & hour law, performance evaluations, discrimination and retaliation, legislated laws protecting employees, and Title VII. All staff are required to keep training logs to ensure compliance.

Non—English speaking Individuals: Bilingual (Spanish/English) staff are available on a regular basis. ASL interpretation is available via subcontract. The agency has the ability to contract with interpreters of other languages on an as-needed basis.

Accessibility: Facilities are in compliance with requirements specified in Section 504 of the Americans with Disabilities Act. The premises at 2568 Park Central Boulevard have been modified as follows for persons with a mobility impairment, sensory impairment, or other physical disability: accessible path of travel from designated spaces in parking lot to lobby and through building; accessible restrooms, doorways, water coolers, and meeting rooms.

Payer and funding sources: ACR accepts the following insurances:

1. Georgia Medicaid (Peach Care)
2. AmeriGroup Medicaid
3. Peach State Medicaid
4. Cenpatico Medicaid

5. CareSource Medicaid
6. Medicare

Fees: Individuals or families themselves can pay for the services that they receive. Ability to pay will not be deciding factor on whether not an individual receives services from ACR. Discounts are offered based on family size and annual income. Information on ACR Fees for self-pay and the sliding fee scale is available in Policy 07.11 - Sliding Fee Discount Application.

ACT, Peer Support, C&A and Adult Outpatient Treatment Fees for Services

Name of Services	Length of	Cost for Services
Mental Health Evaluation (Bio-psychosocial Assessment/Behavioral Health Assessment)	60 to 90 Minutes	• 60 minutes session = $50.00
DUI Assessment	60 Minutes	• $75.00
Diagnostic Assessments	45 to 50 minutes	• Physician Cost- $275.00
Court - Ordered Evaluations	50 to 60 minutes	• LPC, LCSW, LMFT,CACII-$75.00
Psychological Testing	3 to 5 hours	• Licensed Psychologist- begins at
Physician visit/Psychiatric Treatment	20 to 30 minutes	• Licensed Psychiatrist - begins at
Individual Counseling	50 to 60 minutes	• Licensed Staff (LPC, LCSW, LMFT,
Family Counseling	50- to 60 minutes	• Licensed Staff (LPC, LCSW, LMFT,
Group Counseling to include Anger Management Groups (must have a mental health and substance abuse evaluation completed by agency)	60 to 90 minutes	• Licensed Staff (LCSW, LPC, LMFT,
Peer Support and Life Skills Training	3 to 4 hours	• Paraprofessional Staff (e.g. High School Diploma, bachelor degree
Verification of program participation (e.g. judicial system, landlords) except for job and school excuses are given within a 48 hour turn around after	10 to 15 minutes	• Administrative or Paraprofessional staff - $10.00 per
Anger Management Workbook and replacement fee		• Administrative Staff- Cost is
10 Panel Urine Drug Screen		• Cost is $55.00 (Millennium
6 months Sliding Scale Psychiatric Treatment Package Assessments and Treatment Planning Two face to face therapy sessions a month		• Total Cost-$2,500.00 • $75.00 Initial Deposit with 90 days to pay off balance.

Policy 21.02 - Brief Stabilization and Core Recovery Program

Service Area: Metropolitan Atlanta to include the City of Atlanta, Clayton, Cherokee, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale, Newton Counties.

Service Title: Brief Stabilization and Core Recovery Program

Location: 2568 Park Central Blvd, Decatur, GA 30035-3916

Phones: 404-508-0078 (office) 404-508-0071 (fax)

email: ACR_Leadership@ACRHealthGA.com

website: www.ACRHealthGA.com

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	9AM-12PM	9AM-12PM	9AM-12PM	9AM-12PM	9AM-12PM	9AM - 1PM	
PM	1PM-5PM	1PM-5PM	1PM-5PM	1PM-5PM	1PM-5PM		
Evening		6PM-9PM	6PM-9PM	6PM-9PM			
By Appt	6PM-9PM				6PM-9PM	1PM-5PM	1PM-5PM

Administrative Offices:

Location: 2568 Park Central Blvd, Decatur, GA 30035-3916

Phones: 404-508-0078 (office) 404-508-0071 (fax)

Hours of Operation: Monday — Friday, 8:00 a.m. to 5:00 p.m.

Population(s) Served: Adults 18 and older over the age of 18 years old who exhibit mental and/or behavioral health problems who may also exhibit problems with substance abuse. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.

Mental and behavior health issues addressed:

a) Schizophrenia and Other Psychotic Disorders
b) Mood Disorders
c) Anxiety Disorders

d) Adjustment Disorders (By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor or its consequences)
e) Mental Disorders Due to a General Medical Condition Not Elsewhere Classified

Exclusions: The following disorders are excluded unless co-occurring with a qualifying primary Axis I mental or substance related disorder that is the focus of treatment:

a) Tic disorders,
b) Mental Retardation
c) Learning Disorders
d) Motor Skills Disorders
e) Communication Disorders
f) Organic Mental Disorders
g) Pervasive Developmental Disorders
h) Personality Change Due to a General Medical Condition
i) Mental Disorder NOS Due to a General Medical Condition
j) V Codes

Adult Addictive Diseases

a) Substance-Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal.
b) Note that severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
c) Exclusions:
   1. Caffeine-Induced Disorders
   2. Nicotine-Related Disorders
   3. Substance Intoxication - only excluded for Ongoing Services

NOTE: The presence of co-occurring mental illnesses, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation. Individuals diagnosed with the excluded Axis I mental disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I mental illness or substance related disorder. The qualifying Axis I mental illness or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the individual must meet the functional criteria listed above.

Eligibility Determination:

There are four variables for consideration to determine whether an individual qualifies as a "Core Customer" for adult mental health and addictive disease services.

1. **Age:** An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.

2. **Diagnostic Evaluation:** The state DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnostic impression/diagnosis.

3. **Functional/Risk Assessment:** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes the individual's resource utilization, role performance, social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

4. **Financial Eligibility:** The individual must be receiving Medicaid or pre-approved by the Department of Behavior Health and Developmental Disease for State funded services.

Service Abstract: The agency subclass is an outpatient clinic. Assertive Community Recovery, LLC, provides community based services to adults experiencing difficulties with their mental or behavior health and who may other problems with substance abuse, depression, anxiety, relationships, personality, work, and daily living using a wellness and recovery approach. *Note: Individuals must have a qualifying Axis I diagnosis as identified above and not otherwise excluded as stated*. Services provided include screening and assessment; evaluation and diagnosis; counseling; case coordination; case management, and medication services. Clinical assessment includes a recommended level of care appropriate to the severity of substance abuse and other biopsychosocial factors. An emergency safety response is not used at these facilities.

ACR Adult Outpatient Programs are provided in both the community and in clinic. Utilizing evidenced-based practices, such as Cognitive Behavioral, Multisystemic, Dialectical Behavioral therapies, a wide range of services are organized within a comprehensive therapeutic environment that includes screening and assessment, diagnostic determination, individual and family counseling, psychiatric consultations, medication management, crisis intervention, group counseling, educational programming, client advocacy, and referral to community resources. Participants are assigned to licensed clinicians who assist in individual planning and care. Services additionally include consultation with family and/or professional care providers.

Assessment: ACR conducts a brief assessment to make a rapid determination of an individual's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further evaluation and admission to at least Brief Stabilization services.

1. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, or if the individual does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided.

2. If the individual does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the individual may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive assessment process (possibly resulting in the individual moving directly into Ongoing Services).

Program Services/Continuum of Care: ACR Adult Outpatient Programs provide a continuum of care that ensures all Participants and family members referred are evaluated and provided services and/or referred to primary and secondary service providers to meet their individual needs. Team members respond to the participants in a culturally competent manner and assist with empowering each person served to promote recovery, progress, or well-being. The specific areas that demonstrate a continuum of care are as follows:

a. **Screening and Intake Assessment:** A screening and intake process is completed within 24 hours of the initial visit. The strengths, hopes, needs, abilities, and preferences of each client are identified explicitly for integration within an individual plan of care.
b. **Comprehensive Individual Planning:** An individual plan is developed with each participant within the first 14 days of treatment. The client is a full participant in the process and goals and objectives are based on individual needs, strengths, abilities and preferences. Goals are stated in the client's own language, and the client has open access to the individual plan upon request.
c. **Diagnostic Assessment:** A diagnostic interview examination conducted by the team psychiatrist includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis);screening and/or assessment of any withdrawal symptoms for individuals with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to face evaluation of the individual and may include communication with family and other sources, as well as the ordering and medical interpretation of laboratory or other medical diagnostic studies.
d. **Community Support Services:** Community Support services consist of rehabilitative skills building, the development of environmental supports and resources coordination considered essential to assist a person in improving functioning, gaining access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual.
e. **Individual, Group, and Family Therapy:** Each client is assigned a licensed or license eligible therapist who is responsible for the client's coordination of care. Individualized, group, and/or

family therapy sessions take place to assist the client in both individual treatment plan goals and objectives.

f. **Individual, Group and Family Skill Training:** Teaching the skills that enhance functioning and promote the recovery of the individual. Skill training is provided to individuals in groups of other individuals with similar needs or with identified family groups. Skills taught include illness and medication self-management knowledge and skills (e.g. symptom management; behavioral management; relapse prevention skills; knowledge of medications and side effects; and motivational/skill development in taking medication as prescribed); problem solving and practicing functional skills; healthy coping mechanisms; adaptive behaviors and skills; interpersonal skills; daily living skills; resource access and management skills; and understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention.

g. **Crisis Intervention:** Emergency response to mental health crisis is available 24 hours a day, 7 days a week. Staff utilizes an on call system and procedures that ensure all situations requiring specialized crisis intervention are responded in a timely and effective manner.

h. **Medication Management:** Medication management is available to assist with an increase in life functioning. Through the services of qualified physicians, medications are prescribed and their efficacy is evaluated on an ongoing basis. Education is provided to individuals and their care givers regarding the effects, use, and expected outcomes of medication. Individuals have access to psychiatric care 24 hours a day, 7 days a week, either through crisis center response, or referral to an acute psychiatric hospital setting.

i. **Nursing Assessment & Care:** Nursing assessments are provided and interventions developed to observe, monitor and care for the physical, nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of an individual's treatment; assess and monitor the effects of medications, educate individuals about their medications, teach self administration and teach benefits of prescribed medications, consulting with the individual and individual-identified family and significant other(s) about medical, nutritional and other health issues and referred to other medical services as needed to address whole wellness issues.

j. **Psychosocial Education:** Psychosocial education is available to Individuals, families, care providers in both individual and group formats and provided to assist with interpersonal relations, role performance, anger management, and communication skills.

k. **Progress Reviews and Individual Plan Reformulation**: Regular scheduled meetings are held with each client to review the progress of their individual goals and update and/or revise the Individual Plan.

l. **Transition/Discharge Planning and Criteria:** Transition/Discharge planning occurs throughout all phases of the program. The person served has met discharge criteria when the goals of the individual plan are achieved and referral to support services is completed, when appropriate.

Note: Specific Details of each service is detailed in The Provider Manual For Community Mental Health, Developmental Disabilities And Addictive Diseases Providers For The Department Of Behavioral Health & Developmental Disabilities which can downloaded from www.apsero.com.

Mechanisms to Address the Needs of Special Populations: ACR Adult Outpatient Program addresses the special needs of the Individuals served through the development and ongoing monitoring and modification of the individual plan. Through this process, the strengths, abilities, needs, preferences and desired outcomes will be developed based on the unique qualities of the Individuals served. Specific accommodations to address special needs may include the following amplification devices and writing boards for use with hearing impaired Individuals, magnification sheets for the visually impaired, and language interpretation of non-English speaking Individuals.

Support of Adequate Resources to Deliver Programming: ACR's Adult Outpatient Program is supported through multiple processes that ensure adequate resources are available to provide programming consistent with the established goals. The processes are as follows:

a. **Annual Budget Process:** The annual budget process involves an annual assessment of all program's resource needs. The CEO meets with staff and seeks input regarding resources to support the program. The CEO is involved in the budget process with the leadership team and advocates for the needs of the program. After the preliminary budget if finalized, the team is provided an opportunity to provide feedback to the CEO in regards to possible outcome effects of decreased line items. After the final budget is approved, the needs of the programs are assessed monthly at the leadership team's meeting and funding can be modified depending on the needs and circumstances of individual programs.

b. **Performance Improvement/Outcome Management:** The outcome management system is utilized by management team to review and assess the level in which program goals and objectives are being met. Areas that are not meeting program goals and objectives are reviewed to determine if adjustments in areas such as personnel, facilities, transportation, and other resources are needed to support the program goals. The management team utilizes this information to make resource allocation decisions for program support.

c. Strategic Planning: ACR participates in an ongoing strategic planning process through developing and monitoring its short and long-range strategic plan goals and objectives. Strategies to support the goals of the Outpatient program are included in the plan.

d. **Political Advocacy:** Staff participates in local, state, and national advocacy groups throughout service areas. The CEO is actively involved in relationship development that will assist with determining the future of mental health services in the state.

Program Goals: The overall goal of ACR Adult Outpatient Program is to support the recovery, health, and wellbeing of the persons serviced and increase the quality of life through the provision of specialized outpatient mental health services. Specific areas of focus include:

a. Recovery
b. Vocation/Education
c. Parenting
d. Relationships

e. Housing
f. Spirituality
g. Coping Skills
h. Anger Management
i. Grief and Loss

Program Objectives: ACR's Adult Outpatient Program seeks to achieve the following specific objectives:

a. To improve mood and affect in daily living, and build resiliency.
b. To improve social, familial, and social functioning and support the integration of the person served into the community.
c. To reduce the need for a higher level of care.

Admission/Readmission Criteria: Individual must be age 18 or over or an emancipated minor, and must be in need of and willing to participate in treatment. Individual may have co-existing mental health and substance abuse disorders. Individual must meet the admission criteria as specified in the Provider Manual Part I Eligibility and Service Requirements. Individual must also agree to participate in the development and implementation of an individualized treatment plan and be capable of actively participating in a structured group treatment program. Persons who wish to return for additional services may do so as long as they meet admission criteria. All individuals meeting admission criteria receive services. Services will be declined to persons under 18 years of age and who is not an emancipated minor, persons who refuse to participate in treatment offered, and persons for whom there are no funding mechanisms. Persons who wish to return for additional services may do so as long as they meet admission criteria.

Continuing Stay Criteria: Are specified services provided in the Provider Manual Part I Eligibility and Service Requirements.

Discharge/Transfer Criteria: Individual has successfully completed treatment goals, or is unsuccessful due to inappropriate behavior, lack of attendance, or noncompliance with treatment plan. Individual requests discontinuation of services or moves out of the service area. Individual requests a transfer or referral to a different agency within the service area. Individuals can be referred to another agency at their request. Additional criteria that might precipitate a referral would include lack of a funding stream for the services requested or client moving out of the geographical service area.

Discharge/Transfer Against Medical Advice: All individuals will be assessed for risk of harm to self or others prior to discharge. If an individual determined to be dangerous refuses to remain in treatment, the Clinical Director will consult with attending psychiatrist to transfer individual to other provider or to an in-patient facility as appropriate.

Participant/Staff Ratio: 30:1

21.02 - Brief Stabilization and Core Recovery Program

Evidenced based Therapeutic Models and Interventions used when working with ACT consumers.

a) Cognitive Behavior Therapy
b) Solution Focused Brief Therapy
c) Reality Therapy
d) Prescription of medications within specific parameters
e) Training in self-management of illness
f) Family psychoeducation
g) Supported employment,
h) Integrated treatment for co-occurring sub stance use disorders.
i) Recovery Model concepts
j) Peer Whole-Wellness
k) Motivational Interviewing Strategies
l) Wellness Recovery Action Plan (WRAP)
m) Illness Management and Recovery (IMR)
n) Integrated Dual Disorders Treatment (IDDT)

Policy 21.03 - Assertive Community Treatment (ACT)

Introduction

Assertive Community Treatment (ACT) Program is a person-centered recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

The important characteristics of ACR's ACT program are:

- The ACT Team serves individuals with severe and persistent mental illness who also experience difficulties with daily living activities and tasks and because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, this consumer group is often over represented among individuals who are homeless or are in jails and prisons, and have been unfairly thought to resist or avoid involvement in treatment.
- ACT services are delivered by a group of multi-disciplinary mental health and behavior health staff members who work as a team and provide the majority of the treatment, rehabilitation, and support services consumers need to achieve their goals. The team is directed by a team leader and a psychiatric prescriber and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program or administrative support staff who work in shifts to cover 24 hours per day, seven days a week and to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, which are based on consumer need and a mutually agreed upon plan between the consumer and ACT team). The responsibility for addressing the needs of individuals needing support is shared by the team.
- ACT services are individually tailored with each consumer and address the preferences and identified goals of each consumer. The approach with each consumer emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
- The ACT team is mobile and delivers services in community locations to enable each consumer to find and live in their own residence and find and maintain work in community jobs rather than expecting the consumer to come to the program. Seventy-five percent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for consumers.
- ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many consumers benefit from the availability of a longer-term treatment approach and continuity of care. This allows consumers opportunity to recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

Program Objectives: It is expected that individuals receiving ACR ACT services will:

- Experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services.
- Through individualized, team-based supports, it is expected that individuals will achieve:
    - housing stability
    - decreased symptomatology (or a decrease in the debilitating effects of symptoms)
    - medication side effects
    - improved social integration and functioning
    - increased movement toward self-defined recovery

21.03 - Assertive Community Treatment (ACT)

Definitions

Assertive Community Treatment (ACT) is a self-contained comprehensive mental health program made up of multi-disciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. ACT services are individually tailored with each consumer through relationship building, individualized assessment and planning, and active involvement with consumers to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The ACT team is mobile and delivers services in community locations rather than expecting the consumer to come to the program. Eighty (80) percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for consumers. The consumers served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. Staff ratio's are maintained low, no more than 10-12 consumers to one staff member.

Activities of Daily Living Services include approaches to support and build skills in a range of activities of daily living (ADLs), including but not limited to finding housing, performing household activities, carrying out personal hygiene and grooming tasks, money management, accessing and using transportation resources, and accessing services from a physician and dentist.

Clinical Supervision is a systematic process to review each consumer's clinical status and to ensure that the individualized services and interventions that the team members provide (including the peer specialist) are planned with, purposeful for, effective, and satisfactory to the consumer. The team leader and the psychiatric prescriber have the responsibility to provide clinical supervision which occurs during daily organizational staff meetings, treatment planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, treatment plans, progress notes, correspondence).

Comprehensive Assessment is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the consumer and his/her recovery planning team in pursuing goals. The results of the information gathering and analysis are used to: 1) establish immediate and longer-term service needs with each consumer; 2) set goals and develop the first person-centered treatment plan with each consumer; and 3) optimize benefit that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

Consumer is a person who has agreed to receive services and is receiving person-centered treatment, rehabilitation, and support services from the ACT team.

Co-Occurring Disorders Services include integrated assessment and stage-based treatment for individuals who have a co-occurring mental health and substance use disorder. This type of treatment is based on a harm reduction model (vs. a traditional or abstinence-only substance abuse treatment model).

Crisis Assessment and Intervention includes services offered 24 hours per day, seven days per week for consumers when they are experiencing crisis.

Daily Log is a notebook, cardex, or computerized form which the ACT team maintains on a daily basis to provide: 1) a roster of consumers served in the program; and 2) for each consumer, a brief documentation of any treatment or service contacts which have occurred during the day and a concise behavioral description of the consumer's clinical status and any additional needs.

Daily Organizational Staff Meeting is a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program consumers; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

Daily Staff Assignment Schedule is a written, daily timetable summarizing all consumer treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly consumer schedules.

Family and Natural Supports' Psychoeducation and Support is an approach to working in partnership with families and natural supports to provide current information about mental illness and to help them develop coping skills for handling problems posed by mental illness as experienced by a significant other in their lives.

Individual Therapy includes verbal therapies that help people make changes in their feelings, thoughts, and behavior in order to move toward recovery, clarify goals, and address stigma. Supportive therapy and psychotherapy also help consumers understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and evaluate treatment and rehabilitative services. Current psychotherapy approaches include cognitive behavioral therapy, personal therapy, and psychoeducational therapy.

Initial Assessment and Person-Centered Treatment Plan is the initial evaluation of: 1) the consumer's mental and functional status; 2) the effectiveness of past treatment; 3) the current treatment, and rehabilitation and support service needs, and 4) the range of individual strengths that can act as resources to the person and the ACT treatment team in pursuing goals. The results of the information gathering and analysis are used to establish the initial treatment plan to achieve individual goals and support recovery. Completed the day of admission, the consumer's initial assessment and treatment plan guides team services until the comprehensive assessment and full person-centered treatment plan is completed.

Medication Distribution is the physical act of giving medication to consumers in the ACT program by the prescribed route which is consistent with state law and the licenses of the professionals privileged to prescribe and/or administer medication (e.g., psychiatric prescribers, registered nurses, and pharmacists).

Medication Error is any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

Medication Management is a collaborative effort between the consumer and the psychiatric prescriber with the participation of the treatment team to carefully evaluate the consumer's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other medication; to choose a medication treatment; and to establish a method to prescribe and evaluate medication according to evidence-based practice standards.

ACT Case Manager has the primary responsibility for establishing and maintaining a therapeutic relationship with a consumer on a continuing basis, whether the consumer is in the hospital, in the community, or involved with other agencies. In addition, he or she is the responsible team member to be knowledgeable about the consumer's life, circumstances, and goals and desires. The case manager develops and collaborates with the consumer to write the person-centered treatment plan, offers options and choices in the treatment plan, ensures that immediate changes are made as the consumer's needs change, and advocates for the consumer's wishes, rights, and preferences. The case manager also works with other community resources, including consumer-run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the

consumer. The case manager provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people.

Peer Support and Wellness Recovery Services include services which serve to validate consumers' experiences, provide guidance and encouragement to consumers to take responsibility for and actively participate in their own recovery, and help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce consumers' self-imposed stigma. Such services also include *counseling* and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness.

Person-Centered Treatment Plan is the culmination of a continuing process involving each consumer, their family and/or natural supports in the community, and the ACT team, which individualizes service activity and intensity to meet the consumer's specific treatment, rehabilitation, and support needs. The written treatment plan documents the consumer's strengths, resources, self-determined goals, and the services necessary to help the consumer achieve them. The plan also delineates the roles and responsibilities of the team members who will work collaboratively with each consumer in carrying out the services.

Psychiatric and Social Functioning History Time Line is a format or system which helps ACT staff to organize chronologically information about significant events in a consumer's life, experience with mental illness, and treatment history. This format allows staff to more systematically analyze and evaluate the information with the consumer, to formulate hypotheses for treatment with the consumer, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer.

Psychotropic Medication is any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or antianxiety agents.

Service Coordination is a process of organization and coordination within the multi-disciplinary team to carry out the range of treatment, rehabilitation, and support services each consumer expects to receive per his or her written person-centered treatment plan and that are respectful of the consumer's wishes. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

Shift Manager is the individual (assigned by the team leader) in charge of developing and implementing the daily staff assignment schedule; making all daily assignments; ensuring that all daily assignments are completed or rescheduled; and managing all emergencies or crises that arise during the course of the day, in consultation with the team leader and the psychiatric prescriber.

Social and Community Integration Skills Training includes services to support social and interpersonal relationships and leisure time activities, with an emphasis on skills acquisition and generalization in integrated community-based settings.

Supported Education provides the opportunities, resources, and supports to individuals with mental illness so that they may gain admission to and succeed in the pursuit of post-secondary education, including high school, GED, and vocational school,

Symptom Management is an approach directed to help each consumer identify and target the symptoms and occurrences of his or her mental illness and develop methods to help reduce the impact of those symptoms.

Multi-disciplinary Approach specifies that team members share roles and systematically support each as other as they work collaboratively on assisting consumers to achieve their recovery and wellness goals. The approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give and-take among all members (inclusive of the consumer and, if desired, his/her family/other natural supports) on a

regular, planned basis. Treatment planning and implementation is carried a cross-disciplinary, integrated fashion and actively involve the consumer in their own assessment and treatment. All team members contribute to the development of treatment plans.

Treatment Plan Review is a thorough, written summary describing the consumer's and the ACT Team's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan.

Treatment Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, and the consumer and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the consumer's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each consumer and his/her goals and aspirations and for each consumer to become familiar with each ACT staff person; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each.

Treatment Team **(TT)** have a range of clinical and rehabilitation skills and expertise. The TT members are assigned by the team leader and the psychiatric prescriber to work collaboratively with a consumer and his/her family and/or natural supports in the community by the time of the first person-centered treatment planning meeting or thirty days after admission. The core members are the primary practitioner, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each consumer. The TT has continuous responsibility to be knowledgeable about the consumer's life, circumstances, goals and desires; to collaborate with the consumer to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a consumer's needs change; and to advocate for the consumer's wishes, rights, and preferences. The TT is responsible to provide much of the consumer's treatment, rehabilitation, and support services. TT members are assigned to take separate service roles with the consumer as specified by the consumer and the TT in the treatment plan.

Vocational Services include work-related services to help consumers value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers.

Weekly Consumer Contact Schedule is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) that fulfill the goals and objectives in a given consumer's person-centered treatment plan. The ACT Team shall maintain an up-to-date weekly consumer contact schedule for each consumer per the person-centered treatment plan.

Wellness Management and Recovery Services are a combination of psychosocial approaches to working with the consumer to build and apply skills related to his or her recovery, including development of recovery strategies, psychoeducation about mental illness and the stress vulnerability model, building social support, reducing relapses, using medication effectively, coping with stress, coping with problems and symptoms, and getting needs met within the mental health system and community.

TARGET POPULATLION

ACT Program is designed to serve those Core Consumers who have a severe and persistent mental illness as listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living and for which other community mental health programs have not been effective or not deemed appropriate to manage illness. Priority

is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals must have a primary mental health diagnosis. Individuals with a sole diagnosis of a substance use disorder, mental retardation, brain injury or Axis II disorders are not the intended consumer group for ACT services. Individuals who have not been able to remain abstinent from drugs or alcohol will not be excluded from ACT services. Persons served by ACT often have co-existing problems such as homelessness, substance abuse problems, or involvement with the judicial system.

Admission Criteria

1) Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. Priority is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) or bipolar disorder, because these illnesses more often cause long-term psychiatric disability;

and

2) Individuals with significant functional impairments as demonstrated by the inability to consistently engage in at least two of the following:
   a) Maintaining personal hygiene;
   b) Meeting nutritional needs;
   c) Caring for personal business affairs;
   d) Obtaining medical, legal, and housing services;
   e) Recognizing and avoiding common dangers or hazards to self and possessions;
   f) Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or other relatives;
3) Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities);
4) Maintaining a safe living situation (e.g., repeated evictions or loss of housing);

and

5) Individuals with one or more of the following problems that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month):
   a) High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or extended hospital stay (60 days within the past year) or psychiatric emergency services.
   b) Persistent, recurrent, severe, or major symptoms (e.g., affective, psychotic, suicidal).
   c) Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels I, II.1, II.5, III.3, III.5).
   d) High risk or a recent history of criminal justice involvement (e.g., arrest and incarceration).
   e) Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless.
   f) Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
   g) Inability to participate in traditional clinic-based services;

and

6) A lower level of service/support has been tried or considered and found inappropriate at this time.

Continuing Stay Criteria

1) Individual meets the requirements above;

and

2) Demonstrates continued inability to participate in traditional office setting or community setting at a less intense level of service/supports;

and

3) Lives in substandard housing, homeless, or at imminent risk of becoming homeless related to the behavioral health issues

Discharge Criteria

An adequate continuing care plan has been established; and one or more of the following::

a) No longer meets admission criteria;

or

b) Goals of the Individualized Recovery Plan have been substantially met; ;

or

c) Individual requests discharge and is not in imminent danger of harm to self or others, ;

or

d) d. Transfer to another service/level of care is warranted by a change in individual's condition, ;

or

e) e. Individual requires services not available in this level of care.;

Discharge of individuals with severe and persistent mental illness from an ACT program requires special procedures and ACR's ACT will observe the following:

1) Discharges from the ACT team occur when consumers and ACT staff mutually agree to the termination of services. This shall occur when consumers:
   a) Have successfully reached individually established goals for discharge and when the consumer and program staff mutually agree to the termination of services.
   b) Move outside the geographic area of ACT Team's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to a ACT program or another provider wherever the consumer is moving. The ACT team shall maintain contact with the consumer until this service transfer is completed.
   c) Demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without requiring ongoing assistance from the program for at least one year without significant relapse when services are withdrawn.
   d) Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable person-centered treatment plan with the consumer.
2) In addition to the discharge criteria listed above based on mutual agreement between the consumer and ACT staff, a consumer discharge may also be facilitated due to any one of the following circumstances:
   a) Death.
   b) Inability to locate the consumer for a prolonged period of time.
   c) Long-term incarceration.
   d) Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the ACT team that the consumer will not be appropriate for discharge for a prolonged period of time.
   e) If the consumer is accessible at the time of the team shall ensure consumer participation in all discharge activities, as evidenced by documentation as described below:
   f) The reasons for discharge as stated by both the consumer and the ACT team.
   g) The consumer's biopsychosocial status at discharge.
   h) A written final evaluation summary of the consumer's progress toward the goals set forth in the person-centered treatment plan.
   i) A plan developed in conjunction with the consumer for follow-up treatment after discharge.
   j) The signature of the consumer, and the team leader.
3) When clinically necessary, the team will make provisions for expedited re-entry of discharged consumers as rapidly as possible and will prioritize them on the admission and/or waiting list.

21.03 - Assertive Community Treatment (ACT)

Exclusions

1) ACT is a comprehensive team intervention and most services are excluded. Peer Supports and Group Training/Counseling are the exceptions.
2) On an individual basis, up to four (4) weeks of service can be provided to ACT consumers to allow an individual to transition to and from ACT and other community services (e.g., Psychosocial Rehabilitation, Community Supports Team & Individual). The transition plan must be adequately documented in the Individualized Recovery Plan and clinical record.
3) Those receiving Medicaid MR Waivers are excluded from the service.
4) **Clinical Exclusions:** Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis:
    a) Mental retardation
    b) Autism
    c) Organic
    d) Mental disorder
    e) Substance-related disorder

Service Intensity and Capacity

1) **Staff-to-Consumer Ratio:** ACR's ACT team shall maintain the organizational capacity to provide a minimum staff-to consumer ratio of at least one full-time equivalent (FTE) staff person for every 10 consumers. Note the team leader, psychiatrist and case manager are not included in determining staff ratios).
2) **Staff Coverage :**Staff is organized and procedures are in place to provide crisis intervention and support services to ACT consumers 24 hours a day, seven days per week.
3) **Frequency of Consumer Contact**
    a) The ACT team shall have the capacity to provide multiple contacts per week with consumers experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on consumer need and a mutually agreed upon plan between consumers and program staff. Staff shall share responsibility for addressing the needs of all consumers requiring frequent contact.
    b) The ACT team shall have the capacity to rapidly increase service intensity to a consumer when his or her status requires it or a consumer requests it.
    c) The ACT team shall provide an average of three contacts per week for all consumers. Data regarding the frequency of consumer contacts shall be collected and reviewed as part of the program's Continuous Quality Improvement (CQI) plan.

a) **Gradual Admission of Team Consumers:** The ACT team shall stagger consumer admissions (e.g., 4-6 consumers per month) to gradually build up capacity to serve no more than 80-100 consumers.

Staff Requirements

1) **Qualifications**

    The ACT team shall have among its staff, persons with sufficient individual competence and professional qualifications and experience to provide the services described in Georgia DBHDD's Provider Manual Part I Eligibility and Service Requirements for ACT Programs to include:

    - Service coordination
    - Crisis assessment and intervention
    - Recovery and symptom management
    - Individual counseling and psychotherapy
    - Medication prescription, administration, monitoring and documentation
    - Substance abuse treatment
    - Work-related services
    - Activities of daily living services
    - Social, interpersonal relationship and leisure-time activity services

- Support services or direct assistance to ensure that consumers obtain the basic necessities of daily life;
- Education, support, and consultation to consumers' families and other major supports.

B. Team Size and Composition

1) 1. Staffing patterns will be maintain so that client/staff ratio of 10-12 clients to each direct service FTE.

2) 2. At a minimum ACR Will employ the following staff for each ACT team;
   a) **Team Leader (Full-Time):** Serves as the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be an independently licensed practitioner (example LPC, LCSW, LFMT, RN) and have at least 2 years of documented experience working with adults with a SPMI. The Team Leader who is a registered nurse must hold a four-year degree (BSN).
   b) **Psychiatrist** (Full-Time or Part-Time): Provides clinical and crisis services to all team consumers, work with the team leader to monitor each individual's clinical and medical status and response to treatment, and direct psychopharmacologic and medical treatment.
   c) Registered Nurse (1-FTE): Provides nursing services for all team consumers and who must work with the team to monitor each individual's physical health, clinical status and response to treatment.
   d) **Substance Abuse Specialist** (1/2 to 1-FTE): Certified Addiction Counselor (CAC)-I (or an equally recognized SA certification equivalent or higher) who must work on a fulltime or half-time basis to provide or access substance abuse supports for team consumers.
   e) **Mental Health Therapist** (1-FTE): A practitioner licensed to provide psychotherapy/counseling under the Georgia practice acts or a person with an associate license who is supervised by a fully licensed clinician must provide individual and group support to team consumers (this position is in addition to the Team Leader).
   f) **Certified Peer Specialist (CPS) (1-FTE):** Provides rehabilitation and recovery support functions. Because of their life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote consumer self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each consumer's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.
   g) **Paraprofessionals (or professionals) (1-3 FTE):** who must provide services under the supervision of a Licensed Clinician. Paraprofessionals assist consumers with a wide range of rehabilitation and recovery support functions and assistance, providing skills training, community support and linking with natural supports. Paraprofessional are a bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. All paraprofessionals must complete the Georgia Essential Learning Program within 90 days of hire.
   h) **Vocational Rehabilitation Specialist (1-FTE):** Provides vocational rehabilitation training and support to assist consumers return or maintaining meaningful work opportunities, either paid of volunteer..Typically a Vocational Rehabilitation Specialist will have a master's degree in rehabilitation counseling or at least one year of experience in employment services (e.g., job development, job placement, supported employment). Preference will be given to people who have experience in working with individuals with mental illness.
   i) ***Program/Administrative Assistant*** **(1-FTE):** The program/administrative assistant is responsible for organizing, coordinating, and monitoring all nonclinical operations of the ACT team, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for consumer and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and consumers.

21.03 - Assertive Community Treatment (ACT)

Clinical Operations

1) Individuals receiving ACT services must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2) Because ACT-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized, recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for "generic" content of the IRP shall not extend beyond one initial authorization period.
3) Because many individuals served may have a mental illness and co-occurring addiction disorder, the ACT team may not discontinue services to any individual based solely upon a relapse in his/her addiction recovery.
4) ACR's ACT Teams are designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. Staff will remain vigilant in protecting an individual and their family's confidentiality when meeting consumers in their natural settings. Staff will be trained to recognize that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as an agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view). Staff should dress in a manner that does bring undue attention to clients or to the staff member; particularly nurses are reminded not wear uniforms when working with clients in the office or in the community.
5) ACT Team members must stay conscious and aware of the early signs of decompensation when working with clients. Staff members also must stay aware of their surroundings and at times remember that their personal safety is most important. Anytime that a staff member feels unsafe in a particular environment they must remove themselves as expeditious as possible and call for help from other team members. Staff will be trained On "Guidelines For Supporting Adults With Challenging Behaviors In Community Settings" and crisis intervention techniques.
6) **Evidenced based Therapeutic Models and Interventions used when working with ACT consumers.**
    a) Cognitive Behavior Therapy
    b) Solution Focused Brief Therapy
    c) Reality Therapy
    d) Prescription of medications within specific parameters
    e) Training in self-management of illness
    f) Family psychoeducation
    g) Supported employment,
    h) Integrated treatment for co-occurring sub stance use disorders.
    i) Recovery Model concepts
    j) Peer Whole-Wellness
    k) Motivational Interviewing Strategies
    l) Wellness Recovery Action Plan (WRAP)
    m) Illness Management and Recovery (IMR)
    n) Integrated Dual Disorders Treatment (IDDT)

7) **Responsibilities of the ACT team.**
    a) The team's primary function is to develop the a comprehensive and individualized service plan with the person served that is responsive to his/her self determine goals and needs.
    b) The team utilizes a person centered approach that addresses:
        i) Explores and documents the strengths and needs of the person;
        ii) Establishes and prioritizes service goals;
        iii) Identifies the supports necessary to meet those goals;

iv) Describes a course of action encompasses in a written plan within 30 days of the intake developed by team members;
v) Monitors and recognizes accomplishments;
vi) Determines the responsibilities of all team members un these efforts;
vii) Continually updates assessment;

Program Description

1. Team meetings are held 5 times a week with time dedicated to the discussion of the support of a specific individual which is documented and placed in the medical record.

2. Services and interventions are highly individualized and tailored to the needs and preferences of the individual with the goal of maximizing independence and supporting recovery.

3. At least 60% of all service units must involve face-to-face contact with consumers. At least 80% of face-to-face service units will be provided in locations other than the office (including the individual's home, based on individual need and preference and clinical appropriateness).

4. The ACT Team provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis and all individuals participating in ACT must receive a minimum of 4 face-to-face contacts per month.

5. The Team will see each individual once a month for the purpose of symptom assessment/management and management of medications.

1) Hours of operation:
a) Crisis Support: ACR staff is available 24-hours a day/seven days a week for crisis, with an on-call clinician available to address clients needs.
b) Normal operations: 8:30 am to 8:00 pm Monday through Friday.
c) Weekend: Staff is available by appointment on weekends to meet the needs of clients

2) Inter-team Communication Plan:
a) The ACT team meets 5-days week to discuss treatment issues, service delivery and support needed by consumers.
b) Ad Hoc meetings are called as necessary to address crisis and risk of harm. These Ad Hoc meetings are generally telephone conferences.

3) **Telemedicine:**
a) Telemedicine generic term used to describe transmission of medical information from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
b) Telemedicine will used only when all other attempts to have a reluctant consumer to meet the ACT team psychiatrist have failed. Telemedicine will only be used when all other attempts have failed to have consumer see the team psychiatrist to include consumer agreeing to see another psychiatrist. The use of telemedicine will be limited and even though used by team, the use of telemedicine in a specific incidence may or may not approved for Medicaid reimbursement.

Policy 21.04 - PEER SUPPORT PROGRAM

Program Description

Assertive Community Recovery offers a Peer Support Service Center for adults who meet the Core participant criteria. Program staff works collaboratively with participants and their families on skills needed to increase functioning & independence in the community.

Service locations are:

Assertive Community Recovery (ACR) Peer Center
2568 Park Central Blvd
Decatur, GA 30035-3919

Usual hours of operation are between 10:00am and 3:00pm, Monday through Friday with at least 5 hours of service provided 5 days per week. Weekend and after hours activities are provided as scheduled with participant input. Work hours may vary for staff depending on the needs of the participants.

Program Philosophy

The philosophy of ACR Peer Support program is based on the belief that providing a service to adults with severe and persistent mental illness or co-occurring disorders in a mutual peer support manner that is safe and easily accessible manner. This allows individuals to provide peer-to-peer support that aide in helping them manage symptoms, improve daily living/work skills, and utilize community resources. The program is participant driven with decisions about program activities decided upon by the participants. The participant advisory council meets monthly and plans the activities for the next month.

Rehabilitative treatment is provided in a peer-to-peer support manner between and among individuals who have common needs utilizing an evidenced based program called: Wellness Recover Action Plan (WRAP), Peer Support Whole Health, Neuro-science Treatment Team Partner Program, Kathleen Sciacca "Co-Occurring Psychiatric and Substance Disorders Treatment," Prohaska "Motivational Interviewing," Adams & Grieder's "Treatment Planning for Person-Centered Care "and the Huges and Weinstein's "Best Practices in Psychosocial Rehabilitation." Peer services are intended promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills.

Program Goals

The goals are to provide a participant-run, community-based center where its individuals can find a place to achieve mutual support, encourage self-reliance and provide participant directed services that builds upon the strengths, needs, abilities and preferences of individuals being served.

Participants who qualify for and would benefit from Peer Support Services are identified through initial and ongoing assessments designed to identify the skill needs of the participant. A discussion is held with each participant and their family regarding available services. An Individual Service Recovery Plan (ISRP) is developed identifying participant goals and services. Participant choice and participation in the development of goals and services is vital to ensuring that services are directed toward optimizing the empowerment of the individuals. The primary Goals of Adult Peer Support Services are:

- Offer the peer perspective in supporting participants in this service.
- Promotion of socialization, recovery, and self-advocacy.
- Development of natural supports and maintenance of community living skills.
- Development of natural support system.
- Maintenance of skills learned in other support services.
- Increase and maintain independence in the community.

Service Description

Peer Support Services provides structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are participant motivated, initiated and/or managed, and assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring participant purpose beyond the identified mental illness, by exploring possibilities of recovery, by tapping into participant strengths related to illness self-management, by emphasizing hope and wellness, by helping participants develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual), and by assisting participants with relapse prevention planning. The program provides a safe, structured recovery environment in which participants can meet and provide mutual support.

Target Population

Adults who have serious mental illness or co-occurring mental illness and substance abuse related disorder; and one or more of the following;

- Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; or

- Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; or
- Individual may need assistance and support to prepare for a successful work experience;
- Individual may need peer modeling to take increased responsibilities for his/her own recovery; or
- Individual may need peer supports to develop or maintain daily living skills;
- GAF Range: 35 to 70.

Exclusion Criteria:

- Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or
- Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury.
- Individuals admitted to a Crisis Stabilization Program (not including transitional beds within a crisis stabilization program).

Continued Stay Criteria:

- Progress notes document participant progress relative to goals identified in the Service Plan, but treatment goals have not yet been achieved and
- Individual continues to meet admission criteria.

Discharge/Transfer Criteria:

- An adequate continuing care plan has been established; and one or more of the following:
- Goals of the Individualized Recovery/Resiliency Plan have been substantially met; or
- Participant/family requests discharge; or
- Transfer to another service/level is more clinically appropriate.

Mechanisms to Address the Needs of Special Populations

Reasonable and appropriate accommodations are established within the program to assist all participants in receiving the services they need. Buildings are “ADA accessible”

Program Resources

- Services are under the clinical supervision of a Mental Health Professional (MHP) and ideally who is credentialed by the Psychiatric Rehabilitation Professional (CPRP).
- The individual leading and managing the day-to-day operations of the program is a Georgia-certified Peer Specialist who is credentialed by the Psychiatric Rehabilitation Professional (CPRP) or is actively working toward the CPRP credential.
- The Program Leader is employed at least 0.5 FTE.
- The Program Leader is present at least 75% of the hours the Peer Supports program is in operation.
- There are two (2) Peer Specialist in the Peer Supports program.

- Services and activities are lead by Peer Specialist.
- The maximum face-to-face ratio is not more than 30 participants to 1 certified Peer Specialist based on average daily attendance.
- The maximum face-to-face ratio is not more than 15 participants to 1 direct program staff based on average daily attendance.
- Staff has an understanding of recovery and psychosocial rehabilitation principles as defined by the Georgia Participant Council and psychosocial rehabilitation principles and possesses the skills and ability to assist other participants in their own recovery processes.
- Accommodation provided includes space for group activities, and a cafeteria.
- Buildings are “ADA accessible” with wheelchair ramps, accessible restrooms, and other appropriate accommodations.
- Services are provided at sites with sufficient space and facilities to allow effective service delivery. In addition to safe and heated / air-conditioned premises, every site has network connections and hardware to allow all clinicians ready access to the agency’s computerized and integrated clinical care management system.
- Individuals are provided assistance with in obtaining transportation to and from the program as needed to include assistance in obtaining Non-emergency Medical Transportation (NEMT), MARTA cards and linking with other transportation resources.

21.05 – Housing Support Program

ACR Health Services provides Housing Support through a contract with the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD).

The Housing Support program represents a critical component of Permanent Supportive Housing as outlined in the Evidence Based Practices Toolkit from SAMHSA. In its fullness, this program is comprised of recovery supports to sustain permanent housing. The Housing Support program is a required element of the program for all individuals entering the Georgia Housing Voucher Program (GHVP) or renewing their lease under GHVP, as of October 1, 2021. All enrolled individuals are expected to engage in the Housing Support program in order to promote community integration, coordination of desired services, and long-term housing stability. Access to housing is not contingent upon the acceptance of treatment services, in accordance with the Housing First philosophy and approach.

The Housing Support program is comprised of multiple supports designed to assist individuals living in GHVP-subsidized permanent supportive housing to promote ongoing housing stability. All individuals enrolled in the Housing Support program must receive the following types of support:

1. Assistance with housing search, leasing, and move-in processes;
2. Purchase of initial household furnishing, deposits, household goods for the one-time move-in needs;
3. Safety and wellness checks and housing safety inspections;
4. Developing a Housing Stability Support Plan as an adjunct to an individual's IRP;
5. Early intervention to mitigate factors impacting housing stability (e.g. late rent payment, lease violations, tenant/landlord or property owner conflicts);
6. Education on the roles, responsibilities, and rights of tenant(s) and the landlord/property owner; and
7. Assistance with the annual housing recertification and inspection process.

All individuals enrolled in the Housing Support program shall receive any of the following supports, according to their needs and preferences:

1. Completion of supportive housing referral and application processes;
2. Landlord engagement, recruitment, and enrollment;
3. Coaching on relationship-building with landlords/property owners, managers, and neighbors, and assisting in dispute resolution; and
4. Linking with community resources to prevent eviction.

This program is provided to adults enrolled in GHVP in order to promote housing stability, wellness, independence, recovery, and community integration. Housing stability is measured by ongoing housing and by decreased number of

hospitalizations/ER visits/incarcerations, by decreased frequency and duration of crisis episodes, and by increased and/or stable participation in maintenance of personal housing stability and wellness. Supports based on the individuals' needs are used to promote resiliency while understanding the effects of SPMI and lived trauma. The Housing Support staff will serve as the first point of contact for landlords/property owners for any issues arising with a supportive housing individual, and will provide linkage to community; general entitlements; and psychiatric, substance use disorder, medical services, crisis prevention, and intervention services.

The Housing Support program is comprised of a group of interventions including items 1-8 below as well as elements which are defined herein which are not billable via traditional rehabilitation codes. Supports are based on individual need and could include (but are not limited to) the coordination of DBHDD services with community services/supports and financial assistance to help offset the costs of an approved provider's staff time for non-billable activities such as travel, meeting and conference attendance, trainings, and other related activities.

Specific allowable DBHDD behavioral health services (see the Service Definition/Requirements for each service listed below in the DBHDD Provider Manual):

1. Case Management (CM)
2. MH and/or SUD Peer Supports (PS)
3. Psychosocial Rehabilitation – Individual (PSR-I)
4. Addictive Disease Support Services (ADSS)
5. Crisis Intervention
6. Community Support – Individual (CSI)
7. Community Residential Rehabilitation (CRR-IV)
8. Community Transition Planning (CTP)

Admission Criteria

1. Individual must be 18 or older and have a severe and persistent mental illness (SPMI).
2. Individual must be enrolled in the Georgia Housing Voucher Program (GHVP). (Includes individuals with a Notice to Proceed for GHVP, meaning those who have received a voucher and are in the housing search process.)

Continuing Stay Criteria: Individual continues to meet admission criteria.

Discharge Criteria: Individual no longer meets admission criteria.

Service Exclusions: Behavioral Health Residential Programs are excluded (MH or SUD).

Required Components:

1. The Housing Support program must be provided through a team approach (as evidenced in documentation). It focuses on building and maintaining a positive relationship with the individual, facilitating needed independent living supports,

and working toward recovery goals.

2. The Housing Support program must include a variety of interventions in order to assist the individual in developing:
    a. Recovery orientation and skills to work toward their personal recovery goals related to their ability to live independently.
    b. Illness self-monitoring and self-management of symptoms.
    c. Strategies and supportive interventions for developing positive relationships/avoiding conflicts with neighbors and property owner.
    d. Relapse prevention strategies and plans.
3. Required tasks include checking on and documenting the following on a monthly basis:
    a. Individual wellness, need for additional supports or connection to other community resources;
    b. Household wellness, health and safety of the housing unit;
    c. Community integration and relationships with property/neighbors;
    d. Household financial stability.
4. Contact requirements for individuals receiving the Housing Support program:
    a. Contact must be made a minimum of once a week during the first three months of being housed to ensure individuals remain stabilized,
    b. After the first three months of being housed, then contact must be made a minimum of twice each month, one of which must be in the individual's residence/unit and include items 3(a-d).
    c. Half of these contacts must be face-to-face and the other half may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences.
5. At least 50% of HSI service units must be delivered face-to-face with the identified individual receiving the service and at least 80% of all face-to-face service units must be delivered in the individual's home over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers).
6. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of four telephone contacts in that specified month.
7. Unsuccessful attempts to make contact with the individual are not billable.
8. DBHDD services provided via the Housing Support service must adhere to all DBHDD service definitions and requirements for each service provided.

Staffing Requirements

1. Housing Support providers must, at a minimum, have the following positions on staff:
    a. 1-FTE Program Director dedicated (licensed: LCSW, LPC, or LMFT); and
    b. At least 1 FTE Housing Specialist/Case Manager (practitioners who can

provide Case Management services as defined in the BH Provider Manual) who is responsible for providing all of the supports described herein.

2. Peer Support is a critical component of recovery. Individuals being served by a Housing Support provider must have access to a CPS-MH that can provide Peer Support services. There must be documented engagement by the staff team with a CPS-MH.
3. Housing Support must maintain a maximum ratio of 25 individuals per staff member; however, a ratio of 20 individuals per staff member is recommended.
4. Provider must adhere to the Staffing Requirements section of the Service Definition/Requirements for the specific DBHDD service being provided, as well as to all other staffing/professional requirements found elsewhere in the DBHDD's Provider Manual for Community Based Behavioral Health Providers.

Service Accessibility

To promote access, Telemedicine may be as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:

a. The use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters;

and/or

b. The use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.

Service Delivery Location

Housing Support Program services will be provided by a mixture of telephone calls, face to face contacts in the community, at the individual's residence and other places where the individual may need housing support services.

Housing Support Office Address:

ACR Health Services
2568 Park Central Blvd
Decatur, GA 30035-3916

Hours of Operation:

Monday – Friday 9:00 am to 5 pm
Other hours by appointment by calling 404-508-0079 ext 700

Training and Supervision of Case Managers:

A. All case managers will be trained in:

1. The National Alliance for Direct Support Professionals (NADSP) 15 Competency Areas (Annex - 21.17a). Case Manager Supervisors will adhere to the National Frontline Supervisor Competencies. (Annex - 21.17b).
2. Columbia-Suicide Severity Rating Scale (C-SSRS).

Evidenced by Practices used by the Housing Support Program:

- Housing First
- DBHDD Case Manager Toolkit

Policy 21.06 - Crisis Intervention

I. POLICY:

A. It is the policy of ACR to ensure that the emergency mental health needs of all clients are addressed twenty-four hours a day, seven days a week. The organization will maintain an "on-call" system when staff is not available at the clinic to cover the emergency mental health needs of all clients.

II. PROCEDURES:

A. The on call system will be activated during non-program hours when full-time day staff is not available at the facilities. Program hours are Monday through Friday from 9:00 am to 9:00 pm, and Saturday from 9:00 am to 1:00 pm. A cellular phone will be activated at all times outside of the program hours. The phone number will be provided to all clients through a variety of methods that will include: Client handbook and in clinic brochures.

B. Coverage for the on-call system will be established on a rotation basis. Crisis phone coverage will be handled by the leadership team. Each coverage period will be one month in length, from the first day of the month at 8:00 am to the last day of the month at 8:00 am.

C. An on call schedule will be developed each quarter by the administrative assistant and distributed to all persons responsible for coverage.

D. An employee will be designated as the "Crisis Intervention Coordinator" and will be responsible for the following:

1. On call/crisis intervention policy and procedure development and revision.
2. Serve as the backup for all on call personnel.
3. Responsible for coordinating on-call schedule changes.
4. Responsible for communicating all on-call schedule changes.
5. Cell phone maintenance

E. All persons responsible for crisis phone coverage that are unable to fulfill call duties for any reason will initiate action to find a replacement for their scheduled time of duty, and will notify the Crisis Intervention Coordinator of the change.

F. When a designated crisis intervention staff receives a call, they will respond as follows:

1. If it is determined that the person is at harm to self or others the following will apply:

    a. If a situational crisis is occurring that is an immediate threat to client or others, identifying information will be sought and 911will be contacted and reported that a behavioral emergency is in progress.

    b. Following contact with emergency personnel, program sponsor will be contacted and apprised of the situation.

2. If it is determined that the person is experiencing a medical problem the following will apply:

    a. The on-call staff will seek information to fully assess the situation and determine if the clinic's physician needs to be contacted.

    b. If it is determined that the clinic's physician needs to be contacted, call back number will be obtained from client and physician will be called to advise of the situation. In this circumstance, the physician will determine actions to be taken.

3. If it is determined that the situation is not of an emergency nature that threatens the client's physical or mental health status, the following will apply:

    a. The client will be advised to attend the clinic as soon as clinic hours permit and request to see his/her counselor to further discuss and assess the situation that precipitated the call.

G. All calls will necessitate the completion of a critical incident report, as per the organization's policy in this area.

III. Risk Assessment:

All staff members who come into contact with individuals in seeking treatment will be trained the using the Columbia-Suicide Severity Rating Scales (C-SSRS) that is

appropriate for their role in order to assess the severity and intensity of suicidal ideation and to document the full range of behaviors with a lethality measure for suicide attempts. ACR has adapted for use the various Columbia-Suicide Severity Rating Scales (C-SSRS):

1. Form 21.06a Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment - Adult
2. Form 21.06b Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime Recent - Clinical
3. Form 21.06c Columbia-Suicide Severity Rating Scale (C-SSRS) Since Last Visit - Clinical
4. Form 21.06d Columbia-Suicide Severity Rating Scale (C-SSRS) Pediatric/Cognitively Impaired – Lifetime Recent - Clinical
5. Form 21.06e Columbia-Suicide Severity Rating Scale (C-SSRS) Pediatric/Cognitively Impaired - Since Last Visit - Clinical
6. Form 21.06f Columbia-Suicide Severity Rating Scale (C-SSRS) - Clinical Practice Screener -Recent
7. Form 21.06g Columbia-Suicide Severity Rating Scale (C-SSRS) Clinical Practice Screener - Since Last Visit

Policy 21.07 - Intensive Family Program Philosophy

Purpose:

To provide a full range of services that are designed to prevent out of home placement, the need for more intensive/restrictive services and promote improve family functioning.

Policy:

It is the policy of ACR to provide Intensive Family Intervention services to youth and their families that are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.

Procedure:

1. ACR staff will provide an array of services designed to assist a individual in improving his current level of functioning within the living arrangement. The services can be inclusive of the following:

    - Individual psychotherapy services.
    - Substance abuse services
    - Skill development services, which include the development of
        1. Behavior management skills
        2. Life skills
        3. Conflict resolution skills
        4. Problem-solving skills
        5. Anger management skills
        6. Decision-making skills
        7. Crisis management skills.
    - Family therapy
    - School-based services
    - Crisis management/stabilization services
    - Positive youth development services
    - Nutritional and health services
    - Services coordination
    - Medication management/monitoring services.

2. ACR staff provides services designed to meet the improve the family's functioning:

    - Each family received a comprehensive assessment that family's functioning as well identifying the needs, strengths and preferences.
    - Individual Treatment Plan are developed with the individual and his/her family that are based upon the strengths, needs, abilities and preferences identified in the assessment. Individuals are able to verbalize their goals for recovery.
    - An effective ISP treatment plan is developed, implemented and monitored throughout the duration of Individual enrollment in IFI. The ISP planning, evaluation, and adjustment process includes, but are to be limited to the following settings and processes:

        - Team Staffing/Meetings
        - ISP Meetings
        - Level of Care Determinations
        - Individual and Family Therapy
        - Behavior Modification Models (CBT/BT)
        - Rehabilitative Services
        - Community Resources and Support Services
        - Crisis Planning
        - Emergency Discharge Planning
        - Transition/Discharge Planning

    The Individual Individual Service Plan is evaluated every 30 -45 days by the assigned Clinical Team Leader, in collaboration with the Individual, family, and Treatment Team, to determine adjustments, charges and progress toward goals and objectives outlined in the ISP.
    Upon completion of approximately 75 days of service delivery, all team members and other appropriate stakeholders will review individual's ISP to determine level of progress and further placement options. The Team Leader will schedule a transition conference with the treatment team, individual and family members to begin the transition process. A transition discharge plan will include suggested actions and is signed by the individual to indicate agreement with the plan.

3. Team Leader will utilize interventions from evidenced based treatment such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Motivational Interviewing. Team Members are only allowed to do supportive training. Interventions designed to help aid the individual and family to obtain the goals of their treatment plan, and to assist the therapist in implementing and reinforcing various therapeutic techniques.

4. IFI services focuses on the functioning of the entire family and therefore, services may be provided to the family unit as it relates to the well being of the youth. Services include individual and family therapy; individual and family skills training, resource coordination, crisis interventions and wraparound services.

5. The Team leader will establish an on-call schedule that will be given to their families each month. This will allow families to know who they can contact in emergency situations and after normal service delivery hours of 8:00 am to 9:00 pm. In the event of illness or vacation, families will be notified in advance of the absence and who they can contact during their team member's absence.

6. It is imperative that the "team' members do not exceed "2 hours (8 units) maximum per session/meeting unless it is authorized by the Clinical Director as "Crisis Intervention". Moreover, there shall be no "overlapping" of services. There should not be two team members at a home at the same time for service delivery of therapeutic services except in an emergency situation and as authorized by the Clinical Manager.

7. Case Staffing is to take place **EVERY** week, without exceptions, within a team. The team will identify one day per week to conduct staffing. The "Team Leader" should discuss with "team" members progress or lack thereof with cases from the previous week. The "Team Leader" should decide what goals or specific objectives and the type of interventions that will be addressed for the upcoming week. The "Team Leader" is responsible for the implementation of interventions and directing the intensity of treatment. This process allows for improved goal and progress with "clinical" supervision by the licensed Team Leader contributing to more flexibility with service delivery; ensuring the quality of, and accountability for, clinical interventions.

8. To enhance staff's professional skills, knowledge and attitudes in order to achieve competency in providing quality individual care clinical supervision will be provided to

   all team leaders. Clinical supervision will also assist staff in learning from his or her experience and progress in expertise in order to ensure quality direct care service

   delivery. Clinical supervision will be held with IFI team leader/IFI team and the Clinical Director 2 x months to discuss any issues and/or concerns of the client and/or staff.

   Clinical Director will staff at minimum 3 cases per supervision. Any regression and/or progression that the client and family have made will be discussed during clinical supervision. Staff will be provided with interventions to assist those clients with issues, concerns, and those that are not making progress. Clinical director will discuss individual staff progression with professional development and provide recommendations for training and/or supervision.

Policy 21.08 - Intensive Family Intervention Services

Purpose:

To provide a full range of services that are designed to prevent out of home placement, the need for more intensive/restrictive services and promote improve family functioning.

Policy:

It is the policy of ACR to provide Intensive Family Intervention services to youth and their families that are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.

Procedure:

1. ACR staff will provide an array of services designed to assist a consumer in improving his current level of functioning within the living arrangement. The services can be inclusive of the following:

    - Individual psychotherapy services.
    - Substance abuse services
    - Skill development services, which include the development of
        1. Behavior management skills
        2. Life skills
        3. Conflict resolution skills
        4. Problem-solving skills
        5. Anger management skills
        6. Decision-making skills
        7. Crisis management skills.
    - Family therapy
    - School-based services
    - Crisis management/stabilization services
    - Positive youth development services
    - Nutritional and health services
    - Services coordination
    - Medication management/monitoring services.

2. ACR staff provides services designed to meet the improve the family's functioning:

    - Each family received a comprehensive assessment that family's functioning as well identifying the needs, strengths and preferences.
    - Individual Treatment Plan are developed with the consumer and his/her family that are based upon the strengths, needs, abilities and preferences identified in the assessment. Consumers are able to verbalize their goals for recovery.
    - An effective ISP treatment plan is developed, implemented and monitored throughout the duration of Consumer enrollment in IFI. The ISP planning, evaluation, and adjustment process includes, but are to be limited to the following settings and processes:

        - Team Staffing/Meetings
        - ISP Meetings
        - Level of Care Determinations
        - Individual and Family Therapy
        - Behavior Modification Models (CBT/BT)
        - Rehabilitative Services
        - Community Resources and Support Services
        - Crisis Planning
        - Emergency Discharge Planning
        - Transition/Discharge Planning

    The Consumer Individual Service Plan is evaluated every 30 -45 days by the assigned Clinical Team Leader, in collaboration with the Consumer, family, and Treatment Team, to determine adjustments, charges and progress toward goals and objectives outlined in the ISP.
    Upon completion of approximately 75 days of service delivery, all team members and other appropriate stakeholders will review consumer's ISP to determine level of progress and further placement options. The Team Leader will schedule a transition conference with the treatment team, consumer and family members to begin the transition process. A transition discharge plan will include suggested actions and is signed by the consumer to indicate agreement with the plan.

3. Team Leader will utilize interventions from evidenced based treatment such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Motivational Interviewing. Team Members are only allowed to do supportive training. Interventions designed to help aid the consumer and family to obtain the goals of their treatment plan, and to assist the therapist in implementing and reinforcing various therapeutic techniques.

4. IFI services focuses on the functioning of the entire family and therefore, services may be provided to the family unit as it relates to the well being of the youth. Services include individual and family therapy; individual and family skills training, resource coordination, crisis interventions and wraparound services.

5. The Team leader will establish an on-call schedule that will be given to their families each month. This will allow families to know who they can contact in emergency situations and after normal service delivery hours of 8:00 am to 9:00 pm. In the event of illness or vacation, families will be notified in advance of the absence and who they can contact during their team member's absence.

6. It is imperative that the "team' members do not exceed "2 hours (8 units) maximum per session/meeting unless it is authorized by the Clinical Director as "Crisis Intervention". Moreover, there shall be no "overlapping" of services. There should not be two team members at a home at the same time for service delivery of therapeutic services except in an emergency situation and as authorized by the Clinical Manager.

7. Case Staffing is to take place **EVERY** week, without exceptions, within a team. The team will identify one day per week to conduct staffing. The "Team Leader" should discuss with "team" members progress or lack thereof with cases from the previous week. The "Team Leader" should decide what goals or specific objectives and the type of interventions that will be addressed for the upcoming week. The "Team Leader" is responsible for the implementation of interventions and directing the intensity of treatment. This process allows for improved goal and progress with "clinical" supervision by the licensed Team Leader contributing to more flexibility with service delivery; ensuring the quality of, and accountability for, clinical interventions.

8. To enhance staff's professional skills, knowledge and attitudes in order to achieve competency in providing quality consumer care clinical supervision will be provided to

   all team leaders. Clinical supervision will also assist staff in learning from his or her experience and progress in expertise in order to ensure quality direct care service

   delivery. Clinical supervision will be held with IFI team leader/IFI team and the Clinical Director 2 x months to discuss any issues and/or concerns of the client and/or staff.

   Clinical Director will staff at minimum 3 cases per supervision. Any regression and/or progression that the client and family have made will be discussed during clinical supervision. Staff will be provided with interventions to assist those clients with issues, concerns, and those that are not making progress. Clinical director will discuss individual staff progression with professional development and provide recommendations for training and/or supervision.

Policy 21.09 - Intensive Family Intervention Program Plan

Program Philosophy:

It is the philosophy of Assertive Community Treatment Intensive Family Interventions Program to ensure that individuals receive the most appropriate and effective treatment in the least restrictive and most cost-efficient setting. Consumers and family members are empowered to make decisions about their care with the expected outcome of an increased quality of life.

Assertive Community Treatment, LLC. (ACR), a Georgia for profit provider of Intensive Family Intervention (IFI). ACR is approved to serve IFI clients in the eight counties of DBHDD Region 3; Fulton, Cobb, DeKalb, Douglas and Cherokee and Region 1; Bartow. ACR has served clients successfully through contracting with the state and county governmental agencies. Our clinical team is devoted to offering professional, ethical, and person-centered care to all of our clients and the consumers they serve.

Program Description:

A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic foster care, psychiatric residential treatment facilities, or therapeutic residential intervention services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- Defuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
    - Ensure linkage to needed community services and resources; and
    - Improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are

directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency

ACR and IFI target:

- Children and Adolescents exhibiting behavioral problems
- Children and Adolescents associating with antisocial peers
- Children and Adolescents experiencing early substance abuse
- Children and Adolescents responding to disordered family relations

ACR and IFI foster:

- Parental leadership
- Appropriate parental involvement
- Mutual support among parenting figures
- Family communications
- Problem-solving
- Setting clear rules and consequences
- Nurturing
- Shared responsibility for family problems

ACR and IFI benefits to consumers and families.

- Improving youth's self-concept and self-control
- Reducing youth behavior problems, substance use and association with antisocial peers
- Increasing parental involvement by developing positive and effective parenting skills
- Making parental management of children's behavior more effective
- Improving family cohesiveness, collaborations and bonding of child with family
- Improving family communication, conflict resolution, and problems solving skills

Target Population

Children and Adolescents with SED and/or Substance Related Disorders

Youth has a diagnosis and duration of symptoms which classify the illness as SED and/or is diagnosed Substance Related Disorder; **and one or more of the following:**

a. Youth has received documented services through other services modalities (such as Core Services)and/or has exhausted less intensive outpatient services Treatment at a lower intensity has been attempted or given serious consideration, but the risk factors for out-of home placement are compelling; or

b. Youth and/or family has insufficient or severely limited resources or
c. skills necessary to cope with an immediate behavioral health crisis; or
d. Youth and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; or
e. Because of behavioral health issues, the youth is at immediate risk of out-of-home placement or is currently in out-of-home placement (non-institutional) and reunification is imminent (therefore, intensive work needs to begin with the youth and family regarding the youth's treatment goals); or
f. Because of behavioral health issues, the youth is at immediate risk of legal system intervention or is currently involved with DJJ for behaviors/issues related to SED and/or the Substance-related disorder

Discharge criteria –

1. An adequate continuing care plan has been established; **and one or more of the following:**

2. Youth no longer meets the admission criteria; **or**

3. Goals of the Individualized Service Plan have been substantially met; **or**

4. Individual and family request discharge, and the individual is not imminently dangerous; **or**

5. Transfer to another service is warranted by change in the individual's condition; **or**

6. Individual requires services not available within this service.

Expected Benefit – The client should be able to live in the community at the highest level of functioning and lessening the need for out-of placement
Additional Service Criteria:

A. Required Components:

1. The organization has established procedures/protocols for handling emergency and crisis

situations that describe methods for intervention with youth who require psychiatric hospitalization.
2. Each Intensive Family Intervention (IFI) provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities.

3. The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of:

- Staffing pattern in accordance with this definition and how staff is deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff
  absences, illnesses, or emergencies are accommodated,

- Hours of operation, the staff assigned, and types of services provided to consumers, families, parents, and/or guardians,

- How the plan for services is modified or adjusted to meet the needs specified in each
  Individualized Service Plan, and

4. At least 60% of service units must be provided face-to-face with children and their families, and 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period.

5. At least 50% of IFI face-to-face units must include the child (identified consumer). However, when the child is not included in the face-to-face contracts, the focus of the contracts must remain on the child and their goals as identified on their ISP.

6. Documentation of how the team works with the family and other agencies/support systems to build a clinically oriented transition and discharge plan is required.

7. IFI is an individual intervention and may not be provided or billed for more than 1 youth at the same time (including siblings); however, youth participating in an IFI program may receive group skills training and/or group counseling in keeping with his/her individual recovery plan. Siblings who are each authorized to receive IFI must receive individualized services, but family interventions can be done jointly, with only one bill being submitted to the payor (For example, Sibling 1 and Sibling 2 are being seen for 2 units with the parents. Sibling 1 and Sibling 2

each have the documentation in both records, but only one claim for 2 units of reimbursement may be submitted to the payer source).

8. IFI is intended to be provided to youth/families in their living arrangement. Services provided in school settings are allowable up to 3 hours/week as a general rule and the medical record shall include documentation of partnership with the school. Exceptions to this 3 hours/week should be documented to include approval by the IFI Team Leader of clinical need (CAFAS scores, inpatient hospitalization transition, PRTF transition, crisis interventions, etc.). Youth receiving this service must never be taken out of the classroom for the convenience of the service provider.

IFI TREATMENT

Typically a consumer and family will be assigned **a team of one therapist and two paraprofessionals.** Each team member will visit a family on a regular basis, at least once or twice a week. A session usually lasts **60-90 minutes**. The average length of treatment is approximately **one** - **three months.** For more severe cases such as substance abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in the home, community settings, or in the ACR office.
Each Team is eligible to have up to 12 consumers with a team of 3 and up to 16 consumers with a team of 4.
Team of 3 = Team Leader + 2 Paraprofessionals
Team of 4 = Team Leader + 3 Paraprofessionals

INDEPENDENT TEAM ROLES

To provide you with an overview, all individuals providing services operate as a collective unit called the treatment team. The IFI (Intensive Family Intervention) Treatment Team is a therapeutic service team that operates on the basis of providing IFI services through a flexible team approach. This team is composed of a Team Leader, and/or Behavior Specialist, and/or Community Care Specialist. The hierarchy of the treatment team is divided among the team members and is defined as follows:

- **Team Leader**: The Team Leader (TL) is ***licensed*** by the State of Georgia (LPC, LCSW, PhD, PsyD, LMFT) and has three or more years of experience working with children with serious emotional disturbances. The Clinical Director supervises each Team Leader individually and also meets with the team leader's respective team as well on a bi-weekly basis. This individual is responsible for providing ***state licensed therapy and counseling*** to the families that we serve. They report

directly to the Clinical Manager or Clinical Director when the Clinical Manager is not available.

- **Behavior Specialist:** The Behavior Specialist (BS) possesses a Master's degree in a human service delivery area and has three or more years of experience working with children with serious emotional disturbances. This individual is responsible for providing

- ***behavior modification interventions and gauging their effectiveness*** with the families that we service. They work under the supervision of the Team Leader.

- **Community Care Specialist:** The Community Care Specialist possesses a minimum of a high school diploma/GED with no previous mental health experience working with severe, emotionally, and behavior disturbed populations and/or a Bachelor's Degree in a human services delivery area with less than 1 year of mental health experience. This individual is responsible for providing community linkage to assist and support the families that we service. They work under the supervision of the Team Leader.

- Under certain approvals, this individual may possibly be responsible for weekly team meeting notes and reports, if proven to be clinically strong.

Also, an IFI Treatment Team may consist of a 3 - 4 staff. It is the determination of the Clinical Manager on whether there are 2 BS's, 1 BS and 1 CCS, or 2 CCS's.

The family has telephone access to these members on an ongoing basis. Each IFI Treatment Team staff to family ratio will not exceed 12 families, per team at any given time. Team numbers will depend on team dynamics, per the discretion of the Clinical Manager or Clinical Director.

To ensure the maximization of clinical effectiveness, the Clinical Director will meet with the respective teams to ensure that the best possible services are being provided and the highest of ethical treatment is afforded to the families that we serve. To ensure that elite services are being provided, it is necessary to attend these meetings regularly.

Process for enrollment in IFI

Consumers and families may be referred for services by the parent, school or any agency in the community for service provision. However the results of the assessment will determine which program the consumer meets admission criteria for.
Process for enrollment into IFI services:

Referral - Intake –Assessment – Treatment Plan submitted to payor –Approved and assigned to IFI team.

Referrals

The Intake and Referral Department will ensure that all pertinent information is received to effectively process a referral. Information may be obtained from the following sources, but is not limited to: the parent and/or legal guardian, the school, Department of Family and Children Services, Juvenile Court/Probation and Assertive Community Treatment' Support Services Staff. Information may be received for a referral via e-mail, fax, telephone, US postal mail, and hand delivered or completed in person. This information recorded and submitted to the Assessment Manager via referral form or interest form.

Assessment

During the initial interview, the assessor reviews legal documents required in order to provide services needed for the consumer and family, if applicable. These documents include, but not limited to, Authorization for Disclosure, Consent for Treatment, Privacy Practices, Medical Alert, Parent/Guardian-Agency Agreement and Crisis and No Harm Contract. These legal documents are signed prior to the assessor completing the Biopsychosocial assessment as well as other assessment tools utilized during the interview.

The Assessment Department will complete a biopsychosocial assessment for all referrals to determine the need of services based on clinical interpretation and psychiatric diagnoses. After the referral is received by the Assessment Manager and eligibility is determined, consumer information is forwarded to the Assessment Team. The Assessment Team attempts to contact the parent/guardian within 24 hours to schedule a day and time for an initial assessment to be completed. During the interview, a biopsychosocial assessment interview is completed which obtains the following, but not limited to, Family History, Presenting Problems, Master Problem List, Diagnostic Impression, Symptoms and Behaviors, Mental Status Exam, Current and Previous Mental Health Interventions and Medications, Substance Use and Developmental History.

Additional assessments

One of the requirements of our IFI services is that each child has one of the following as deemed clinically necessary and/or required by payor source:

Psychological – A psychological report by a licensed psychologist, within the past year is a state of Georgia requirement. If there is a copy of this at the beginning of treatment, we can use it for our record. ***This is acceptable for the APS and FFS requirements as it relates to the managed care requirements and it meets documentation requirements.***

If a psychological evaluation is needed, it can be performed by the psychologist that is working with the agency.

Psychiatric Assessment

Some of the managed care providers require that some of our consumers see a psychiatrist for a medication evaluation, to see if psychotropic medications are needed. If a child is already on psychotropics, we need to get a copy for the client record and forward it the managed care group if necessary.

For the efficiency of our program, we have an MOU's with area psychologists that can do diagnostic assessments and psychologicals. Also to ensure freedom of choice consumers may be provided with referrals for a psychologist or psychiatrist.

Developing an ISP

An effective ISP treatment plan is developed, implemented and monitored throughout the duration of Consumer enrollment in IFI. The ISP planning, evaluation, and adjustment process includes, but are to be limited to the following settings and processes:

- Team Staffing/Meetings
- ISP Meetings
- Level of Care Determinations
- Individual and Family Therapy
- Behavior Modification Models (CBT/BT)
- Rehabilitative Services
- Community Resources and Support Services
- Crisis Planning
- Emergency Discharge Planning
- Transition/Discharge Planning

The Consumer Individual Service Plan is evaluated every 30 -45 days by the assigned Clinical Team Leader, in collaboration with the Consumer, family, and Treatment Team, to determine adjustments, charges and progress toward goals and objectives outlined in the ISP.
Upon completion of approximately 75 days of service delivery, all team members and other appropriate stakeholders will review consumer's ISP to determine level of progress and further placement options. The Team Leader will schedule a transition conference with the treatment team, consumer and family members to begin the transition process. A transition discharge plan will include suggested actions and is signed by the consumer to indicate agreement with the plan which is reviewed and assessed to:

a) Identify accomplished goals and objectives.

b) Determine future placement options.
c) Determine supports and accommodations required for successful transition.
d) Identify potential barriers to successful transition.

If after review of ISP, it is determined that consumer is in need of reauthorizations for additional services, the Team leader will contact the Utilization Manager to have the reauthorization process initiated which consists of updating the ISP and identifying the frequency of problematic behaviors.

Service Delivery

The official delivery of Intensive Family Intervention services should begin within 24-48 hours of the case being assigned to the team with initial contact being made by the team leader. The service delivery should be clinical in nature. **ONLY the "Team Leader" is allowed to do therapy as per Medicaid guidelines.** Team will utilize interventions from evidenced based treatment such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Motivational Interviewing. Team Members are only allowed to do supportive training. Supportive training defined for this purpose is as follows: Interventions designed to help aid the consumer and family to obtain the goals of their treatment plan, and to assist the therapist in implementing and reinforcing various therapeutic techniques. Recommendations will be given to the "team" members each week by the "Team Leader" to use for interventions. These assignments can be given from the "Homework Planner" to work with the family. The treatment plan/ISP is to be followed. If the treatment needs to be updated or changed, the "team" should offer suggestions during the weekly staffing and implemented by the "Team Leader". The "Team Leader" will be responsible to include the changes on the ISP and on an "Updated" Treatment Plan document. The "Team Leader" and /or the designee must chart in a BIRP note, in the plan section, the "change" as it relates to the consumer's treatment.

It is imperative that the "team' members do not exceed "2 hours (8 units) maximum per session/meeting unless it is authorized by the Clinical Director as "Crisis Intervention". Moreover, there shall be no "overlapping" of services. There should not be two team members at a home at the same time for service delivery of therapeutic services except in an emergency situation and as authorized by the Clinical Manager. The Team leader will establish an on-call schedule that will be given to their families each month. This will allow families to know who they can contact in emergency situations and after normal service delivery hours of 8:00 am to 9:00 pm. In the event of illness or vacation, families will be notified in advance of the absence and who they can contact during their team member's absence.

IFI services focuses on the functioning of the entire family and therefore, services may be provided to the family unit as it relates to the well being of the youth. Services include individual and family therapy; individual and family skills training, resource coordination, crisis interventions and wraparound services.

Case Staffing/Team Supervision

Case Staffing is to take place **EVERY** week, without exceptions, within a team. The team will identify one day per week to conduct staffing. The "Team Leader" should discuss with "team" members progress or lack thereof with cases from the previous week. The "Team Leader" should decide what goals or specific objectives and the type of interventions that will be addressed for the upcoming week. The "Team Leader" is responsible for the implementation of interventions and directing the intensity of treatment. This process allows for improved goal and progress with "clinical" supervision by the licensed Team Leader contributing to more flexibility with service delivery; ensuring the quality of, and accountability for, clinical interventions.

The Team Leader and/or designee should complete a weekly team meeting/supervision notes. The Weekly Notes are maintained in the client files. However, the "Team Leader" and/or their designee is responsible for completing a Monthly Report on each client, with a copy placed in the file and a copy sent to update the referral source. Information in the monthly report should summarize the progress of the consumer/family; identify obstacles to treatment; describe degree and extent of investment in IFI services; explain modifications in treatment plans and treatment prognosis.

Clinical Supervision of Team Leader/Team by Clinical Director

To enhance staff's professional skills, knowledge and attitudes in order to achieve competency in providing quality consumer care clinical supervision will be provided to all team leaders. Clinical supervision will also assist staff in learning from his or her experience and progress in expertise in order to ensure quality direct care service delivery. Clinical supervision will be held with IFI team leader/IFI team and the Clinical Director 2 x months to discuss any issues and/or concerns of the client and/or staff. Clinical Director will staff at minimum 3 cases per supervision. Any regression and/or progression that the client and family have made will be discussed during clinical supervision. Staff will be provided with interventions to assist those clients with issues, concerns, and those that are not making progress. Clinical director will discuss individual staff progression with professional development and provide recommendations for training and/or supervision

Medicaid Billing

Billing is done in 15 minute increments. 1 unit is equal to 15 minutes.
Do not "bill" Medicaid for:

1. Telephone calls for appointment setting or calls that there was no intervention discussed regarding the consumer.
2. Transportation.
3. Services without an intervention.

Billing is due 48 hours after service delivery. Team members will submit invoices each Tuesday by 7:00 pm for the previous week.

The Billing dates submitted **MUST BE THE SAME** as dates on the documentation in the client files.

The Billing Manager is responsible for checking consumer's Medicaid eligibility on a regular basis. It is required that checks occur every week to ensure consumer maintains "active" Medicaid status.

Case Assignment

To ensure that clients receive care in a timely manner cases will be assigned to teams within hours of receiving authorization from utilization department. The clinical director will receive the authorization, assessment and treatment plan from the utilization department via email. The clinical manager will review the assessment in order to determine which IFI team has the knowledge and experience to best serve the consumer and his/her family. The clinical director, once IFI team has been identified, will forward the authorization dates, number of units, assessment and treatment plan to staff via email. Any pertinent information needed by IFI team will be added to the body of the email. The clinical director will update the IFI services assignment sheet after a case has been assigned to any IFI team. The assignment sheet will be updated to reflect the consumer' s name, start and end dates, number of units authorized, insurance carrier and referral source's name. The assignment sheet will also reflect changes in insurance carriers and units. The clinical director will update the assignment sheet once each week and forward the updated assignment sheet to IFI teams, intake/referral, utilization, quality assurance managers and all managers.

In the event the IFI teams are filled to capacity the clinical director will provide individual/family therapy to the family until another team can be created or a vacancy occurs.

Clinical Documentation

ACR requires that all staff submit documentation of service provision in the form of a BIRP note – behavior, intervention, response and plan. The behavior section should identify the frequency and type of problematic behaviors displayed by consumer. The intervention section should list interventions identified on the ISP and explain how the team member implement the intervention with the consumer/family. The response section will discuss the consumer's/family's response to the intervention and level of engagement in the session. The plan section will discuss the plan for future sections. The BIRP note can also incorporate any collateral contacts with referral sources or agencies able to provide assistance to the family. The BIRP note should also indicate what was

gained from the session that the consumer/family can continue to implement after services have been discharged.

Until the paperless system is implemented all notes will send encrypted notes to the IFI Manager via e-mail for verification of progress note accuracy as it relates to justification of services. Notes are to be submitted via e-mail no later than 2 days after the session was completed.

Billing requirements

All team members are required to submit 128 units/32 hours per week or 75% of available units if team assigned less than 128 units. This requirement also provides the client with the necessary 1-2 contacts to provide intensive service provision. Corrective action will be completed on all staff persons that did not meet the billable hour requirements.

Corrective actions will be done in a 3 tier process – 1st verbal with a plan of action to achieve billing requirements, 2nd written with a plan of action to achieve billing requirements and 3rd- termination with HR. Corrective actions will lead to termination if 3 are obtained within the same quarter.

Outcome measures

To provide empirical data as it relates to the providing of services, a CAFAS is done at the beginning of services, every 30-45 days from date of admission, and at discharge. These forms are available from the Clinical Manager.

Discharge summary

At the end of treatment, it is our obligation to our families and referral resources to give them a detailed account of what the therapeutic experience consisted of over the treatment term. This is done in the form of a discharge summary to include CAFAS scores. The families should be preparing for discharge at least two weeks prior to discharge date.

A discharge plan is completed and processed through all appropriate members of the ISP Team prior to consumer discharge from IFI. Team and family discuss transition plan and necessity of continued service provision at a lesser or greater intensity. Appropriate referrals are provided to the family to address treatment recommendations.

All discharged paperwork and documentation is given to the Utilization Manager not more than **48 hours** after the consumer discharge/transition from IFI.

The discharge summary upon completion is forwarded to all individuals who have clearance to receive documentation as it relates to our families. This is also submitted in within two days of discharge.

Policy 21.10 - Case Assignments

Purpose:

To ensure that cases are assigned to the appropriate intensive family intervention services staff within 24 hours of receiving authorization from utilization department. Once a case has been assigned, the intensive family intervention services assignment sheet will be updated to reflect new case.

Policy:

It is the policy of Assertive Community Recovery, LLC. that clients are assigned to the appropriate core services staff based on education, training and credentials within 24 hours of receiving the authorization. The clinical manager is responsible for forwarding the assessment and treatment plan via email to identified staff and administrative staff.

Procedure:

1. The Clinical Manager will receive the authorization assessment and treatment plan from the utilization department via email.

2. The Clinical manager will review the assessment in order to determine which staff has the skills, knowledge and education to best serve the consumer and his/her family.

3. The Clinical manager will assign a team of one therapist and two paraprofessionals. Once staff identified, will forward the authorization dates, number of units, assessment and treatment plan to staff via email. Any pertinent information needed by staff will be added to the body of the email.

4. The Clinical manager will update the core services assignment sheet after a case has been assigned to any core services staff. The assignment sheet will be updated to reflect the consumer' s name, Medicaid number, start and end dates, number of units authorized, insurance carrier and referral source's name. The assignment sheet will also reflect changes in insurance carriers and units.

5. The Clinical manager will update the assignment at least once weekly, and forward the updated assignment sheet to core services staff, intake/referral, utilization, quality assurance managers, clinical manager for IFI, clinical director, and program director.

INDEPENDENT TEAM ROLES

To provide you with an overview, all individuals providing services operate as a collective unit called the treatment team. The IFI (Intensive Family Intervention) Treatment Team is a therapeutic service team that operates on the basis of providing IFI services through a flexible team approach. This team is composed of a Team Leader, and/or Behavior Specialist, and/or Community Care Specialist. The hierarchy of the treatment team is divided among the team members and is defined as follows:

- **Team Leader**: The Team Leader (TL) is ***licensed*** by the State of Georgia (LPC, LCSW, PhD, PsyD, LMFT) and has three or more years of experience working with children with serious emotional disturbances. The Clinical Director supervises each Team Leader individually and also meets with the team leader's respective team as well on a bi-weekly basis. This individual is responsible for providing ***state licensed therapy and counseling*** to the families that we serve. They report directly to the Clinical Manager or Clinical Director when the Clinical Manager is not available.

- **Behavior Specialist:** The Behavior Specialist (BS) possesses a Master's degree in a human service delivery area and has three or more years of experience working with children with serious emotional disturbances. This individual is responsible for providing

- ***Behavior modification interventions and gauging their effectiveness*** with the families that we service. They work under the supervision of the Team Leader.

- **Case Manager/Paraprofessional:** The Case Manager/Paraprofessional possesses a minimum of a high school diploma/GED with no previous mental health experience working with severe, emotionally, and behavior disturbed populations and/or a Bachelor's Degree in a human services delivery area with less than 1 year of mental health experience. This individual is responsible for providing community linkage to assist and support the families that we service. They work under the supervision of the Team Leader.

- Under certain approvals, this individual may possibly be responsible for weekly team meeting notes and reports, if proven to be clinically strong.

Also, an IFI Treatment Team may consist of a 3 - 4 staff. It is the determination of the Clinical Manager on whether there are 2 BS's, 1 BS and 1 PP, or 2 PP's.

The family has telephone access to these members on an ongoing basis. Each IFI Treatment Team staff to family ratio will not exceed 12 families, per team at any given time. Team numbers will depend on team dynamics, per the discretion of the Clinical Manager or Clinical Director.

To ensure the maximization of clinical effectiveness, the Clinical Director will meet with the respective teams to ensure that the best possible services are being provided and the highest of ethical treatment is afforded to the families that we serve. To ensure that elite services are being provided, it is necessary to attend these meetings regularly.

Policy 21.11 - Providing Services during School Hours Policy

Policy:

It is the policy of ACR to provide intensive family based services in the school environment for up to 3 hours a week when the behaviors indicate that the school location is the best place to meet the individual's needs and approved by school officials as documented in the students IEP.. Exceptions to 3 hours/week should be documented to include approval by Clinical Director of clinical need.

Procedure:

A. ACR staff will document the partnership with school, and parent when it has been determined that is necessary to provide mental health services at school during school hours.

B. ACR staff will get a school release will be signed by the parent and provided to the school to initiate services in the school.

C. ACR staff will communicate with school officials prior to the first meeting with the student stating the goals to be addressed during treatment.

D. Sessions will be limited to no more than 30 minutes of direct interaction with the student unless previous arrangements with the school and parent have been documented.

E. ACR staff will make all efforts to avoid removing the student from any core classes and/or classes that the youth is not performing well in academically.

Policy 21.12 - Child and Adolescent Outpatient Program
CORE Program Description

1. Program Philosophy:

It is the philosophy of ACR's Child and Adolescent Outpatient Program to assist persons with developing and maintaining coping skills that facilitate adjustment and integration within their living environments and community. Individual Receiving Services and family members are empowered to make decisions about their care with the expected outcome of an increased quality of life. The office is located at 2568 Park Central Blvd; Decatur, GA 30035, Phone Number: 404-508-0078. Office hours are from 8am-5pm M-F. Staff are available via phone 24-hours/day, 7 days/week.

2. Program Description:

ACR Child and Adolescent Outpatient Programs are provided in both the community and in clinic. Utilizing evidenced-based practices, such as Cognitive Behavioral, Effective Parenting, and Dialectical Behavioral therapies. Services are provided to children and adolescents from the age of 4 through the age of 21 (Persons over the age of 18 will not be admitted to services unless documented evidence is presented that indicates that the consumer is actively enrolled in secondary education and he/she is in the custody of the GA Department of Family and Children Services or the GA Department of Juvenile Justice).

A wide range of services are organized within a comprehensive therapeutic environment that includes screening and assessment, diagnostic determination, individual and family counseling, psychiatric consultations, medication management, crisis intervention, group counseling, educational programming, client advocacy, and referral to community resources. Individual Receiving Services are assigned to licensed and license eligible clinicians who assist in individual planning and care. Services additionally include consultation with family and/or professional care providers, to include medication consultation regarding medically related issues.

3. Program Goals:

The overall goal of ACR Child and Adolescent Outpatient Program is to support the recovery, health, and wellbeing of the persons serviced and increase the quality of life through the provision of specialized outpatient mental health services. Specific areas of focus include:

a. Recovery
b. Vocation/Education
c. Parenting
d. Relationships
e. Housing by referral
f. Spirituality
g. Coping Skills
h. Anger Management
i. Grief and Loss

4. Program Objectives:

ACR's Child and Adolescent Outpatient Program seeks to achieve the following specific objectives:

a. To improve mood and affect in daily living, and build resiliency.

b. Enhance the quality of life

c. To improve social, familial, and social functioning and support the integration of the person served into the community, to include employment, volunteer activities, church and civic membership and participation, school attendance, and other age appropriate activities.

d. To reduce the need for a higher level of care.

5. Program Services/Continuum of Care:

ACR Child and Adolescent Outpatient Programs provide a continuum of care that ensures all Individual Receiving Services and family members referred are evaluated and provided services and/or referred to primary and secondary service providers to meet their individual needs. Referrals are received from county DFCS and DJJ offices, schools, Juvenile Courts, other community providers, and the community at large. Team members respond to the Individual Receiving Services in a culturally competent manner and assist with empowering each person served to promote recovery, progress, or well-being. Further, continuity of services are planned for each consumer through development of contingency and future planning. The specific areas that demonstrate a continuum of care are as follows:

a. Screening and Intake Assessment: A screening and intake process is completed within 7 days of the initial visit. The strengths, hopes, needs, abilities, and

preferences of each client are identified explicitly for integration within an individual plan of care.

b. Comprehensive Individual Planning: An individual plan is developed with each consumer within the first 14 days of treatment. The client is a full participant in the process and goals and objectives are based on individual needs, strengths, abilities and preferences. Goals are stated in the client's own language, and the client has open access to the individual plan upon request.

c. Individual, Group, and Family Therapy: Each client is assigned a licensed therapist or license eligible staff who is responsible for the client's coordination of care. Individualized, group, and/or family therapy sessions take place to assist the client in both individual treatment plan goals and objectives. Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

d. Crisis Intervention: Emergency response to mental health crisis is available 24 hours a day, 7 days a week. Staff utilize an on call system and procedures that ensure all situations requiring specialized crisis intervention are responded in a timely and effective manner.

e. Medication Management: Medication management is available to assist with an increase in life functioning. Through the services of qualified physicians, medications are prescribed and their efficacy is evaluated on an ongoing basis. Education is provided to individual Individual Receiving Services regarding the effects, use, and expected outcomes of medication. Individual Receiving Services have access to psychiatric care 24 hours a day, 7 days a week through referrals and contracts with prescribing psychiatrists.

f. Psychosocial Education: Psychosocial education is available to Individual Receiving Services, families, care providers in both individual and group formats and provided to assist with interpersonal relations, role performance, anger management, and communication skills.

g. Support groups: ACR will refer to applicable support services as needed, to include, but not limited to:

1. Peer support
2. Local advocacy groups
3. Consumer/survivor/ex-patient groups

4. Self-help groups

h. Coordination of Services: where required, and with releases of information, ACR will communicate and coordinate services with internal and external service providers to include, but not limited to:

1. other programs within the organization
2. case managers
3. probation officers
4. respite providers
5. employers

i. Progress Reviews and Individual Plan Reformulation: Regular scheduled meetings are held with each client to review the progress of their individual goals and update and/or revise the Individual Plan.

j. Transition/Discharge Planning and Criteria: Transition/Discharge planning occurs throughout all phases of the program. The person served has met discharge criteria when the goals of the individual plan are achieved and referral to support services is completed, when appropriate.

6. Mechanisms to Address the Needs of Special Populations:

ACR Child and Adolescent Outpatient Treatment Program addresses the special needs of the Individual Receiving Services served through the development and ongoing monitoring and modification of the individual plan. Through this process, the strengths, abilities, needs, preferences and desired outcomes will be developed based on the unique qualities of the Individual Receiving Services served. Specific accommodations to address special needs may include the following amplification devices and writing boards for use with hearing impaired Individual Receiving Services, magnification sheets for the visually impaired, and language interpretation of non-English speaking Individual Receiving Services.

7. Support of Adequate Resources to Deliver Programming:

ACR's Child and Adolescent Outpatient Program is supported through multiple processes that ensure adequate resources are available to provide programming consistent with the established goals. The processes are as follows:

a. Annual Budget Process: The annual budget process involves an annual assessment of all program's resource needs. The Clinical Director meets with staff and seeks input regarding resources to support the program. The Clinical Director is involved in the budget process with the management team and

advocates for the needs of the program. After the preliminary budget if finalized, the Clinical Director is provided an opportunity to provide feedback to the Chief Operating Officer in regards to possible outcome effects of decreased line items. After the final budget is approved, the needs of the programs are assessed monthly at the management team's meeting and funding can be modified depending on the needs and circumstances of individual programs.

b. Performance Improvement/Outcome Management: The outcome management system is utilized by management team to review and assess the level in which program goals and objectives are being met. Areas that are not meeting program goals and objectives are reviewed to determine if adjustments in areas such as personnel, facilities, transportation, and other resources are needed to support the program goals. The management team utilizes this information to make resource allocation decisions for program support.

c. Strategic Planning: ACR participates in an ongoing strategic planning process through developing and monitoring its short and long-range strategic plan goals and objectives. Strategies to support the goals of the Outpatient program is included in the plan.

d. Political Advocacy: Staff participates in local, state, and national advocacy groups throughout service areas. The CEO is actively involved in relationship development at both the legislative and state level with key stakeholders that determine the future of mental health services in the state.

Policy 21.13 – Partial Hospitalization Program

Assertive Community Recovery, LLC. (ACR) is a CARF accredited provider that renders services to individuals to support their wellness recovery journey through the use of the most appropriate treatment modality that is tailored to meet the needs of the consumer and their families, as well as assist in the achievement of their individual self-defined treatment goals and wellness needs. Central to our approach is our belief that individuals are in the best position to determine their own treatment needs and in their uniqueness are most qualified determinant of their personal wellness definition. Recovery consists of basic principles such as having hope, choice, self-determination, and personal responsibility. Recovery also involves finding one's niche or gift in life. It is our ***mission*** to ensure that consumers with mental health and substance abuse needs receive the most appropriate and effective treatment in the least restrictive and most cost-efficient setting. ACR is not only committed to helping people live in the community, but also to help people live with the community. To that end, all treatment shall be focused around the principles of recovery, resilience and self-determination.

ACR ***values*** are organized around the core principle of delivering high quality treatment services in a way that is fully accessible and person centered. Pursuit of this principle is guided by a commitment to the provision of treatment that is comprehensive, community based, and delivered in the least restrictive setting with a focus on allowing consumers and their family to have their preferences known and to direct the delivery of treatment.

ACR seeks to expand its service capacity by pursuing licensure to provide treatment services for addictive diseases to better respond to the dearth of quality services and programs available to indigent and special needs populations.

Psychological and Social Interventions

It is our belief that psychotropic medications has an important role in recovery from illness; but not a cure and is best used in conjunction with evidenced based therapies that include family involvement, social and occupation rehabilitation as necessary components of treatment efficacy. Individuals have the right to make informed decisions about all aspects of their health, medications and treatments. Family involvement is a major component of the maintenance of wellness and significantly impacts the individual's ability to remain in the community. The quality of the support that is provided by an empathic family relationship is directly related to increased stability in the community. In that regard, we believe that our role is to assist individuals with identify and develop a meaning supportive relationship with a treatment partner who is family or same as family. Individuals and their family are in control of deciding their treatment needs. We believe our role is to educate individuals on their illness and to teach the resiliency skills that support independence and self-management of illness.

Treatment strategies used at ACR:

ACR will adhere to ASAM Level II.5 criteria to guide implementation of its Intensive Outpatient Drug Treatment Adult Day Program (IOP-Adult) and partial hospitalization treatment program. The program focuses on ensuing important community ties and closely resembles the real life experiences of the consumer served. The program is designed with twenty hours of clinically intense programming based upon the consumer's treatment needs. The program reflects a high degree of structure and scheduling. Structured program will consist of individual counseling, family counseling and group services with psychiatric and medical services readily accessible. Our goal is to bring consumers independently back into society, enabling them to learn to live again addiction-free. Our philosophical approach to care is grounded in the knowledge that the client is the expert in forging his/her path to recovery. We recognize this as a journey or process which will be different for every client. As such, our practices are guided by the Stage of Change Model and Motivational Interviewing Techniques, which forms the basis for partnering with our clients to design interventions to help achieve their desired behavioral change. Thus, our services are undergirded by the integrated themes of self-determination, choice, responsibility, skill building, healing, resiliency, connection, and family and community involvement. This person-centered, recovery-focused approach guides all aspects of our client interactions and is intended to allow them to choose a life course that is not inhibited or defined by their illness(es).

Additional evidenced based therapeutic models and interventions used when working with our consumers include:

1. The use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe.
2. Contingency management
3. Relapse prevention
4. Cognitive-Behavioral Techniques.
5. Skill-building strategies are engaged to assist clients overcome functional deficits in areas such as understanding instructions, repetition
6. Facilitating the participation by clients in 12-Step, Double-Trouble in Recovery and other dual recovery mutual self-help groups because they have demonstrated value as a means of supporting individuals with COD in the abstinent life.

Population Served:

ACR's Partial Hospitalization Program is designed to serve individuals 18 and older who are not currently in high school. Adolescents aged 16 and above, may also attended if the adolescent participates in other adult treatment programs and if is determine that attending adult treatment programs are suited for the adolescent's recovery. It is intended for adults whose treatment needs can largely be met through a moderate intensity, group treatment approach. While the program is primarily a group intervention, individual sessions are included for treatment planning purposes and crisis intervention, and family therapy is provided to address family conflict and communication problems; and to teach the supports and other behaviors needed to help individuals achieve and maintain abstinence.

Treatment Process and Phases:

Phase I - Intake and Assessment

All candidates for the treatment program will be pre-screened for readiness and eligibility. Once eligibility is determined, the intake process will include a brief assessment, after the brief

assessment is conducted, an adult comprehensive assessment of individual capacities, strengths and needs across the wellness and functioning spectrum, i.e., medical, social, cultural, legal, and financial is conducted. Once the initial assessment is complete, the client will work with an assigned Therapist to identify and establish recovery goals.

Phase II - Primary Treatment
During the primary treatment phase, consumer will be assessed for higher treatment need through the use of the agencies comprehensive assessment and alcohol and drug assessment. After the assessment has been completed, consumers will be assigned to the program based upon treatment necessity. They will be assigned a Substance Abuse Counselor, Therapist, Para Professional and nurse who provide a highly structured recovery environment in combination with professional clinical services to support and promote recovery. Aligned with the ASAM Level II.1 and II.5 structured activities will be provided in the mornings and in the evenings.

Activities will include:

1. Educational sessions to discuss the physiological effects of abusing drugs and alcohol.
2. Individual and group counseling to address client motivation and readiness for change, craving, and adoption of new ways of thinking, behaviors and skills.
3. Supports and activities to strengthen interpersonal and coping skills.
4. Social and recreational skill building to teach alternative, alcohol and drug-free behaviors and activities. (The treatment site includes a community garden which is managed by clients who are also residents at the facility.)
5. Case management and wrap-around supports to gain readiness for employment, address transportation needs, and advance capacity for independent living.
6. Access to medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services.

ACR will offer a comprehensive range of treatment services and activities to increase client success and favorable public health outcomes. Treatment protocols will also integrate cognitive-behavioral therapy approaches and 12-step sessions. Clients are given the opportunity to learn, practice and integrate skills learned in treatment. When appropriate, counseling services will include family members to provide a more thoughtfully conceived path to recovery and re-socialization.

Staffing Plan

ACR staff includes a board certified psychiatrist, nurse practitioner, state licensed professional counselors, licensed marriage and family therapist, registered nurses, state certified addiction counselors, paraprofessionals and certified peer specialists. In order to provide the most far-reaching and holistic treatment possible, ACR also contracts with licensed medical providers to address primary health needs that might inhibit optimum functioning.

Facility Description

21.13 - IOP-SA Adult - Partial Hospitalization Program Description

ACR will operate its outpatient treatment program utilizing state approved office space located at 4151 Memorial Drive, Suite 209C, Decatur, GA 30032. At the facility space is designated for group training/education, individual and family sessions.

Policy 21.14 – Substance Abuse (SA) Intensive Outpatient Treatment Program Description

Assertive Community Recovery, LLC. (ACR) is a CARF accredited provider that renders services to individuals to support their wellness recovery journey through the use of the most appropriate treatment modality that is tailored to meet the needs of the consumer and their families, as well as assist in the achievement of their individual self-defined treatment goals and wellness needs. Central to our approach is our belief that individuals are in the best position to determine their own treatment needs and in their uniqueness are most qualified determinant of their personal wellness definition. Recovery consists of basic principles such as having hope, choice, self-determination, and personal responsibility. Recovery also involves finding one's niche or gift in life. It is our ***mission*** to ensure that consumers with mental health and substance abuse needs receive the most appropriate and effective treatment in the least restrictive and most cost-efficient setting. ACR is not only committed to helping people live in the community, but also to help people live with the community. To that end, all treatment shall be focused around the principles of recovery, resilience and self-determination.

ACR ***values*** are organized around the core principle of delivering high quality treatment services in a way that is fully accessible and person centered. Pursuit of this principle is guided by a commitment to the provision of treatment that is comprehensive, community based, and delivered in the least restrictive setting with a focus on allowing consumers and their family to have their preferences known and to direct the delivery of treatment.

ACR seeks to expand its service capacity by pursuing licensure to provide treatment services for addictive diseases to better respond to the dearth of quality services and programs available to indigent and special needs populations.

Psychological and Social Interventions

It is our belief that psychotropic medications has an important role in recovery from illness; but not a cure and is best used in conjunction with evidenced based therapies that include family involvement, social and occupation rehabilitation as necessary components of treatment efficacy. Individuals have the right to make informed decisions about all aspects of their health, medications and treatments. Family involvement is a major component of the maintenance of wellness and significantly impacts the individual's ability to remain in the community. The quality of the support that is provided by an empathic family relationship is directly related to increased stability in the community. In that regard, we believe that our role is to assist individuals with identify and develop a meaning supportive relationship with a treatment partner who is family or same as family. Individuals and their family are in control of deciding their treatment needs. We believe our role is to educate individuals on their illness and to teach the resiliency skills that supports independence and self management of illness.

Population Served:

ACR's IOP-SA Adult Program is designed to serve individuals 18 and older who are not currently in high school. Adolescents aged 16 and above, may also attended if the adolescent participates in other adult treatment programs and if is determine that attending adult treatment programs are suited for the adolescent's recovery. It is intended for adults whose treatment needs can largely be met through a moderate intensity, group treatment approach. While the program is primarily a group intervention, individual sessions are included for treatment planning purposes and crisis intervention, and family therapy is provided to address family conflict and communication problems; and to teach the supports and other behaviors needed to help individuals achieve and maintain abstinence.

Treatment strategies used at ACR:

ACR will adhere to ASAM Level II.1 criteria to guide implementation of its SA Intensive Outpatient Treatment Program. The program is designed with nine hours of structured programming consisting of counseling and group services and with psychiatric and medical needs being addressed as needed. Our philosophical approach to care is grounded in the knowledge that the client is the expert in forging his/her path to recovery. We recognize this as a journey or process that will be different for every client. As such, our practices are guided by the Stage of Change Model and Motivational Interviewing Techniques, which forms the basis for partnering with our clients to design interventions to help achieve their desired behavioral change. Thus, our services are undergirded by the integrated themes of self-determination, choice, responsibility, skill building, healing, resiliency, connection, and family and community involvement. This person-centered, recovery-focused approach guides all aspects of our client interactions and is intended to allow them to choose a life course that is not inhibited or defined by their illness(es).

Additional evidenced based therapeutic models and interventions used when working with our consumers include:

1. The use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe.
2. Contingency management
3. Relapse prevention
4. Cognitive-Behavioral Techniques.
5. Skill-building strategies are engaged to assist clients overcome functional deficits in areas such as understanding instructions, repetition
6. Facilitating the participation by clients in 12-Step, Double-Trouble in Recovery and other dual recovery mutual self-help groups because they have demonstrated value as a means of supporting individuals with COD in the abstinent life.

Treatment Process and Phases:

Phase I - Intake and Assessment
All candidates for the treatment program will be pre-screened for readiness and eligibility. Once eligibility is determined, the intake process will include a brief assessment, after the brief assessment is conducted, an adult comprehensive assessment of individual capacities, strengths and needs across the wellness and functioning spectrum, i.e., medical, social, cultural, legal, and financial is conducted. Once the initial assessment is complete, the client will work with an assigned Therapist to identify and establish recovery goals.

Phase II - Primary Treatment
During the primary treatment phase, clients will be assigned a Substance Abuse Counselor, Therapist, Paraprofessional and nurse which provide a highly structured recovery environment in combination with professional clinical services to support and promote recovery. Aligned with the ASAM Level II.1 structured activities will be provided in the mornings and in the evenings.

Activities will include:

1. Educational sessions to discuss the physiological effects of abusing drugs and alcohol.
2. Individual and group counseling to address client motivation and readiness for change, craving, and adoption of new ways of thinking, behaviors and skills.
3. Supports and activities to strengthen interpersonal and coping skills.

4. Social and recreational skill building to teach alternative, alcohol and drug-free behaviors and activities. (The treatment site includes a community garden which is managed by clients who are also residents at the facility.)
5. Case management and wrap-around supports to gain readiness for employment, address transportation needs, and advance capacity for independent living.
6. Access to medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services.

ACR will offer a comprehensive range of treatment services and activities to increase client success and favorable public health outcomes. Treatment protocols will also integrate cognitive-behavioral therapy approaches and 12-step sessions. Clients are given the opportunity to learn, practice and integrate skills learned in treatment. When appropriate, counseling services will include family members to provide a more thoughtfully conceived path to recovery and re-socialization.

Staffing Plan

ACR staff includes a board certified psychiatrist, nurse practitioner, state licensed professional counselors, licensed marriage and family therapist, registered nurses, state certified addiction counselors, paraprofessionals and certified peer specialists. In order to provide the most far-reaching and holistic treatment possible, ACR also contracts with licensed medical providers to address primary health needs that might inhibit optimum functioning.

Facility Description

ACR will operate its outpatient treatment program utilizing state approved office space located at 4151 Memorial Drive, Suite 209C, Decatur, GA 30032. At the facility space is designated for group training/education, individual and family sessions.

Policy 21.15 - Treatment Program Admission Procedures

1. **Program Management**
    a. **Admission or Readmission Criteria and Procedures:**
        i. ACR's Alcohol and Drug Programs provide outpatient drug free treatment services directed at stabilizing and rehabilitating persons (beneficiaries) with substance abuse diagnoses. Acceptable diagnoses are all of the diagnoses listed in the substance abuse section of the latest version of the Diagnostic and Statistical Manual of Mental Disorders. The primary beneficiaries of treatment services will be individuals who are actively involved in alcohol and drug abuse and who are experiencing the negative consequences associated with alcohol and drug abuse. Significant others of beneficiaries may be involved in the treatment process through collateral services. Any non-collateral service that is provided to individuals without a DSM diagnosis (i.e. co-dependents, dependent personalities) will not be billed through ACR.
        ii. During the intake process, an assessment will be conducted to determine eligibility for admission to services.
    b. **Ages served:**
        i. Adolescents:
            1. Generally, individuals ages 12 -18 who are at the cognitive level of at least eleven (11) years of age. (Exceptions may be made based on recommendations of expert referral sources and with the approval of ACR's Clinical Director.)

                and

            2. meets the DSM diagnostic criteria and ASAM Criteria for Adolescent SA Day Treatment.
        ii. Adults, individuals, age 18 and older, who DSM diagnostic criteria and ASAM Criteria for Adult SA Day Treatment will be served in the Adult Drug Treatment Program.
        iii. Adolescents will be served in the Adolescent Drug Treatment Program. The C&A program and the Adult program will have separate day/times of operation so that there will never be adolescents and adults in the same facility at the same time.
    c. **Criteria for Admission:**

i. The primary criterion for admission to the program shall be involvement with drugs, or problems related to alcohol and/or drug use, including family members or significant others of individuals who are abusing chemicals.
ii. Drugs of abuse may include substances such as methamphetamine, marijuana, prescription medication, cocaine, crack, heroin, PCP, and any unlawful use of sedatives, stimulants, and inhalants.
iii. Statement of Nondiscrimination: Admission shall not be denied on the basis of race, color, religion, sex, sexual orientation, age, national origin or disability.
iv. All participants shall be deemed by the Program Director and the physician to be physically and mentally capable of assuming full responsibility for their own decisions and actions in relation to recovery from alcohol and/or drug misuse.
v. Client referrals are accepted from individuals, family, friends, community agencies and professionals, including physicians, therapists, courts, schools, probation officers, or DFCS workers. Referrals for individuals under the age of twelve (12) years of age will be required to have a parent and/or guardian accompany them to the interview and sign necessary documents that allow ACR to treat minors.
vi. Participation in the program shall be voluntary. Beneficiaries must be willing to participate in all aspects of the program and abide by all rules and regulations. Even individuals who are court-mandated can express their choice to participate in ACR treatment programs. Mandated individuals who refuse to participate or abide program rules will be referred back to the agency mandating services for that agency to take appropriate action.

d. **Readmission:** An individual who desires to be readmitted to a program will go through the same intake procedures as a new admission. Exception to this would be if there were unusual circumstances surrounding the person's prior treatment episode discharge, i.e. an involuntary discharge due to dangerous or threatening behavior while in treatment or discharged due to need for a more intensive treatment program (residential/hospitalization).
e. **Individuals not Accepted for Treatment:** All individuals who are deemed not eligible for services will receive referrals to agencies or programs that may better meet their needs. Individuals in need of detoxification or residential services will be referred to nearby agencies offering those services.
f. Intake
i. An initial interview will be scheduled to determine if an individual meets intake criteria. Persons not meeting intake eligibility will be referred to the most appropriate agency or program.
ii. When eligibility for services has been determined, the ACR staff shall complete an intake packet and provide the individual with an orientation to treatment. The intake and orientation includes, but is not limited to, completing forms related to information on a personal, financial, educational, vocational, and medical level. The intake also requires the

compilation of a detailed substance abuse history of the individual applying for services. A screening tool such as the ASI, SASSI, or MAST may be used to help in diagnosing the individual and determining treatment needs. Appropriate releases of information or requests for information will be completed at intake and necessary signatures will be obtained. The individual will be informed of client rights (fair hearings), confidentiality and privacy practices, program rules and regulations, available treatment modalities, and the expected length of treatment. The individual will sign a consent for treatment form and all intake documents will be placed in a medical records chart with the individual's name on the outside of the chart.

iii. All client records will be kept in the locked ACR medical records office, which meets HIPAA standards.

g. **Intake**

i. ACR's Intake Coordinator will schedule appointments as required. These will normally be done on Monday's between 1pm to 5pm. Walk-ins will be handled on a case-by-case basis.

ii. At a minimum, the following information will be gathered at intake:

1. Social, economic and family background Education
2. Vocational achievements
3. Criminal history, legal status;
4. Medical history
5. Drug history; and
6. Previous treatment episodes

2. Medical Services

a. Each program participant will complete a Nursing Assessment provided by the Program Nurse within 7 days of intake.

b. All program participants will be required to have a recent physical examination by a primary care physician within last 90 days.

c. Program participants will be referred to Oakhurst Medical Center or other available Primary Care Providers for the exam/laboratory work. Program participants can chose go to their personal physician for the exam and lab work. Program participant will be asked to sign a release of information so that the program staff can communicate with the facility conducting the exam/lab work and obtain results.

d. Individuals presenting or reporting symptoms of tuberculosis must obtain clearance from their MD or health clinic prior to admission into one of ACR's alcohol and drug programs.

e. During the intake process, clients are educated about life styles and behaviors that can lead to HIV infection, sexually transmitted diseases, and Hepatitis C. Clients are encouraged to contact the local Public Health Department for further information regarding infectious diseases, testing options, and treatment if needed.

3. Admissions:

Policy 21.15 - Treatment Program Admission Procedures

a. Prior to admission in the Drug Treatment Program, all individuals will have the following procedures completed and reviewed by program MD.
    i. Urine Drug Screen
    ii. TB Test
    iii. Physical Examination
    iv. Sexually Transmitted Diseases Test
b. Program nurse in consultation with program physician will make required referrals for care/treatment if needed.
c. All program participants will have a BioPsychoSocial Assessment, Substance Abuse Assessment and initial treatment plan completed.
d. Final Treatment plan will be completed within 30 days of admission and reviewed every 60 days with the program participant.

Policy 21.15a – Individual Served Drug Testing

I. POLICY:

ACR Health Services (ACR) recognizes that drug and alcohol abuse is one of the most serious health problems in the United States today. The agency feels the issue of drug abuse must be identified, confronted and treated. ACR will require drug screening of individuals served as part of their treatment process. These drugs screening will be conducted at intake and randomly throughout the treatment process.

II. PURPOSE:

To assist the individuals served are resolving their substance use and able live substance free lives.

II. PROCEDURE

A. All individuals tested will be tested for both drug and alcohol consumption irrespective of suspicion or admission to impairment by either drugs or alcohol.

B. Staff will identify a random schedule to conduct the drug screenings.

C. Individual served will be informed of their random screening and MUST submit to the random screening as scheduled. If individual served refuses drug screen, it will be noted as a positive screen.

D. Random screenings may be observed by same sex gender whenever possible; however, when it is not possible, concession will be made for the observation.

E. Staff will perform the screening and follow the chain of custody as outlined in the next section.

F. When applicable, the supervising/referring agency (Probation & Parole, Drug Court, DFCS) is notified when "positive" tests are confirmed by Millennium UDT Drug Testing Laboratories.

G. All positive screens will be discussed with individuals served and a plan will be created to prevent positive screens in the future.

H. **The chain of custody for urinalysis tests are as follows:**

1. Staff (or designee) may individually observe individuals void into a collection cup except where the collector and the individual are not of the same sex or where it is virtually impossible to collect an observed specimen. (For unobserved specimens, an adulteration panel test may be requested.)

2. Staff will follow the directions of the urinalysis tests. Testing will be completed in the presence of the individual. If the test has a 'negative' result, the specimen will be discarded.

3. For those tests that read 'positive,' the urine sample is sent to Millennium for confirmation. The specimen bottle will be placed in the specimen bag with

appropriate labels, identifying information, and security labels then sent to the lab. If appropriate chain of custody labels are not affixed the test will be determined to be invalid by Millennium. Tests are confirmed via GC/MS.

4. When applicable, the supervising/referring agency (Probation & Parole, Drug Court, DFCS, etc.) are notified when 'positive' tests are confirmed by Millennium.
5. Shipping containers. Boxes or bags that are used to transport specimens to the laboratory and can be securely sealed to prevent the possibility of undetected tampering. A shipping container/mailer is not necessary if a laboratory courier hand-delivers the sealed leak-resistant plastic bags containing the specimen bottles directly from the collection site to the laboratory.
6. Secure temporary location. If the sealed leak-resistant plastic bag containing the specimen bottles is not immediately placed in a shipping container, the sealed plastic bag must always be maintained within the line of sight of the collector to ensure that no one has access to the specimen until it is placed in a shipping container or it must be placed in a secured temporary location (e.g., inside a refrigerator that can be secured, inside a cabinet that can be secured). If the collector always places the sealed plastic bags immediately into shipping containers, there is no need to have a secure temporary location available at the collection site.

Policy 21.16 - ACR Drug Treatment Program Description

Assertive Community Recovery, LLC. (ACR) is a CARF accredited provider that renders services to individuals to support their wellness recovery journey through the use of the most appropriate treatment modality that is tailored to meet the needs of the consumer and their families, as well as assist in the achievement of their individual self-defined treatment goals and wellness needs. Central to our approach is our belief that individuals are in the best position to determine their own treatment needs and in their uniqueness are most qualified determinant of their personal wellness definition. Recovery consists of basic principles such as having hope, choice, self-determination, and personal responsibility. Recovery also involves finding one's niche or gift in life. It is our ***mission*** to ensure that consumers with mental health and substance abuse needs receive the most appropriate and effective treatment in the least restrictive and most cost-efficient setting. ACR is not only committed to helping people live in the community, but also to help people live with the community. To that end, all treatment shall be focused around the principles of recovery, resilience and self-determination.

ACR ***values*** are organized around the core principle of delivering high quality treatment services in a way that is fully accessible and person centered. Pursuit of this principle is guided by a commitment to the provision of treatment that is comprehensive, community based, and delivered in the least restrictive setting with a focus on allowing consumers and their family to have their preferences known and to direct the delivery of treatment.

ACR seeks to expand its service capacity by pursuing licensure to provide treatment services for addictive diseases to better respond to the dearth of quality services and programs available to indigent and special needs populations.

Psychological and Social Interventions

It is our belief that psychotropic medications has an important role in recovery from illness; but not a cure and is best used in conjunction with evidenced based therapies that include family involvement, social and occupation rehabilitation as necessary components of treatment efficacy. Individuals have the right to make informed decisions about all aspects of their health, medications and treatments. Family involvement is a major component of the maintenance of wellness and significantly impacts the individual's ability to remain in the community. The quality of the support that is provided by an empathic family relationship is directly related to increased stability in the community. In that regard, we believe that our role is to assist individuals with identify and develop a meaning supportive relationship with a treatment partner who is family or same as family. Individuals and their family are in control of deciding their treatment needs. We believe our role is to educate individuals on their illness and to teach the resiliency skills that support independence and self-management of illness.

Treatment strategies used at ACR:

ACR will adhere to ASAM Level II.1 criteria to guide implementation of its intensive outpatient treatment program. The program is designed with nine hours of structured programming consisting of counseling and group services and with psychiatric and medical needs being addressed as needed. Our philosophical approach to care is grounded in the knowledge that the client is the expert in forging his/her path to recovery. We recognize this as a journey or process that will be different for every client. As such, our practices are guided by the Stage of Change Model and Motivational Interviewing Techniques, which forms the basis for partnering with our clients to design interventions to help achieve their desired behavioral change. Thus, our services are undergirded by the integrated themes of self-determination, choice, responsibility, skill building, healing, resiliency, connection, and family and

community involvement. This person-centered, recovery-focused approach guides all aspects of our client interactions and is intended to allow them to choose a life course that is not inhibited or defined by their illness(es).

Additional evidenced based therapeutic models and interventions used when working with our consumers include:

1. The use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe.
2. Contingency management
3. Relapse prevention
4. Cognitive-Behavioral Techniques.
5. Skill-building strategies are engaged to assist clients overcome functional deficits in areas such as understanding instructions, repetition
6. Facilitating the participation by clients in 12-Step, Double-Trouble in Recovery and other dual recovery mutual self-help groups because they have demonstrated value as a means of supporting individuals with COD in the abstinent life.

Treatment Process and Phases:

Phase I - Intake and Assessment
All candidates for the treatment program will be pre-screened for readiness and eligibility. Once eligibility is determined, the intake process will include a brief assessment, after the brief assessment is conducted, an adult comprehensive assessment of individual capacities, strengths and needs across the wellness and functioning spectrum, i.e., medical, social, cultural, legal, and financial is conducted. Once the initial assessment is complete, the client will work with an assigned Therapist to identify and establish recovery goals.

Phase II - Primary Treatment
During the primary treatment phase, clients will be assigned a Substance Abuse Counselor, Therapist, Para Professional and nurse that provide a highly structured recovery environment in combination with professional clinical services to support and promote recovery. Aligned with the ASAM Level II.1 structured activities will be provided in the mornings and in the evenings.

Activities will include:

1. Educational sessions to discuss the physiological affects of abusing drugs and alcohol.
2. Individual and group counseling to address client motivation and readiness for change, craving, and adoption of new ways of thinking, behaviors and skills.
3. Supports and activities to strengthen interpersonal and coping skills.
4. Social and recreational skill building to teach alternative, alcohol and drug-free behaviors and activities.
5. Case management and wrap-around supports to gain readiness for employment, address transportation needs, and advance capacity for independent living.
6. Access to medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services.

ACR will offer a comprehensive range of treatment services and activities to increase client success and favorable public health outcomes. Treatment protocols will also integrate cognitive-behavioral therapy approaches and 12-step sessions. Clients are given the opportunity to learn, practice and integrate skills learned in treatment. When appropriate, counseling services will include family members to provide a more thoughtfully conceived path to recovery and re-socialization.

Staffing Plan

ACR staff includes a board certified psychiatrist, nurse practitioner, state licensed professional counselors, licensed marriage and family therapist, registered nurses, state certified addiction counselors, para-professionals and certified peer specialists. In order to provide the most far-reaching and holistic treatment possible, ACR also contracts with licensed medical providers to address primary health needs that might inhibit optimum functioning.

Facility Description

ACR will operate its outpatient treatment program utilizing state approved office space located at 4151 Memorial Drive, Suite 209C. The property is comprised of six offices where individual sessions will be held and two group/training rooms, for up to 20 persons each, where group education and family sessions will be conducted.

Policy 21.17 – Case Management

I. POLICY:

A. ACR will assign case managers to coordinate services and supports to help individuals live successfully in the community. As a community mental health agency, ACR case managers will assist individuals in its treatment programs in obtaining the benefits and services necessary to support recovery and resiliency.

B. Case Management services consist of providing environmental support and care coordination considered essential to assist the individual with improving his/her functioning, gaining access to necessary services, and creating an environment that promotes recovery as identified in his/her Individual Recovery Plan (IRP). The focus of interventions include assisting the individual with:

1. Developing natural supports to promote community integration;
2. Identifying service needs;
3. Referring and linking to services and resources identified through the service planning process;
4. Coordinating services identified on the IRP to maximize service integration and minimize service gaps;
5. Ensuring continued adequacy of the IRP to meet his/her ongoing and changing needs.

C. The goal of ACR's case management services is for individuals to have decreased hospitalizations, decreased incarcerations, decreased episodes of homelessness, increased housing stability, increased participation in employment or job related activities, increased community engagement, and recovery maintenance.

II. PROCEDURES:

A. ACR's Case Management Services consist of four (4) major components that cover multiple domains that impact one's overall wellness including medical, behavioral, wellness, social, educational, vocational, co-occurring, housing, financial, and other service needs of the individual:

1. **Engagement & Needs Identification**
   The case manager engages the individual in a recovery-based partnership that promotes personal responsibility and provides support, hope, and encouragement. The case manager assists the individual with developing a community-based support network to facilitate community integration and maintain housing stability. Through engagement, the case manager

partners with the individual to identify and prioritize housing, service and resource needs to be included in the IRP.

2. **Care Coordination**
   The case manager coordinates care activities and assists the individual as he/she moves between and among services and supports. Care coordination requires information sharing among the individual, his/her core provider, specialty provider(s), residential provider, primary care physician, and other identified supports in order to:
   1) Ensure that the individual receives a full range of integrated services necessary to support a life in recovery that includes health, home, purpose, and community.
   2) Ensure that the individual has an adequate and current crisis plan.
   3) Reduce barriers to accessing services and resources.
   4) Minimize disruption, fragmentation, and gaps in service.
   5) Ensure all parties work collaboratively for the common benefit of the individual.

3. **Referral & Linkage**
   The case manager assists the individual with referral and linkage to services and resources identified on the IRP including housing, social supports, family/natural supports, entitlements (SSI/SSDI, Food Stamps, VA), income, transportation, etc. Referral and linkage activities may include assisting the individual to:
   1) Locate available resources
   2) Make and keep appointments
   3) Complete the application process
   4) Make transportation arrangements when needed.

4. **Monitoring and Follow-Up**
   The case manager visits the individual in the community to jointly review progress made toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the individual in order to:
   1) Determine if services are provided in accordance with the IRP.
   2) Determine if services are adequately and effectively addressing the individual's needs.
   3) Determine the need for additional or alternative services related to the individual's changing needs or circumstances.

Notify the treatment team when monitoring indicates the need for IRP reassessment and update.

5. **Treatment Plan**
   The foundation of case management is an ongoing, person-centered individual recovery plan. ACR administers a battery of assessment to determine to identify areas of need, deficits, personal resources and strengths and goals. Our assessments include the BioPsychoSocial Assessment, Psychiatric Diagnostic Assessment, Nursing Assessment, Client's Assessment of Strengths, and Goals (CASIG), Substance Abuse Assessment and Vocational Rehabilitation Assessment. The needs identified in these assessment are used to develop an Individual Recovery Plan (IRP) in coordination with the individual and if appropriate their family. IRP's are updated at regular intervals or whenever a marked change occurs. Case managers will be familiar with IRP for the individuals on their caseload IRP in order to provide assistance as necessary to support the individual in achieving their recovery goals.

B. Risk Assessment: All case managers will be trained in the using the Columbia-Suicide Severity Rating Scales (C-SSRS) that is appropriate for their role in order to assess the severity and intensity of suicidal ideation and to document the full range of behaviors with a lethality measure for suicide attempts. ACR has adapted for use the various Columbia-Suicide Severity Rating Scales (C-SSRS):

1. Form 21.06a Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment - Adult
2. Form 21.06b Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime Recent - Clinical
3. Form 21.06c Columbia-Suicide Severity Rating Scale (C-SSRS) Since Last Visit - Clinical
4. Form 21.06d Columbia-Suicide Severity Rating Scale (C-SSRS) Pediatric/Cognitively Impaired – Lifetime Recent - Clinical
5. Form 21.06e Columbia-Suicide Severity Rating Scale (C-SSRS) Pediatric/Cognitively Impaired - Since Last Visit - Clinical
6. Form 21.06f Columbia-Suicide Severity Rating Scale (C-SSRS) - Clinical Practice Screener -Recent
7. Form 21.06g Columbia-Suicide Severity Rating Scale (C-SSRS) Clinical Practice Screener - Since Last Visit

C. Crisis Planning and Support of Individuals in Crisis

1. Crisis Plans will developed for all individuals in recovery so the individual, families and other supporters as applicable will know what how to respond if the individual experiences a crisis.
2. ACR Policy 21.06 (Crisis Intervention) provides guidance on how a crisis will be handle by the agency. Case Management staff shall familiarize themselves the Crisis Intervention Policy. Case Management staff will support individuals experiencing a crisis throughout the crisis period. The

therapist assigned to the individual's case will coordinate the response to an individual's crisis. Case Managers will contact the therapist for guidance on how to deal with the crisis and provide support as requested. If the individual is hospitalized or confined because of the crisis the Case Manager will remain in contact with the individual during the period of confinement and be ready to support the individual upon discharge or release. Case Managers will be coordinate with the facility's staff (i.e. hospital or jail) to learn ways the individual can be better supported upon their release. Case Managers will coordinate with other members of the individual's recovery team to determine if visits are appropriate and if so which team member will visit the individual during the period of confinement. A member of the recovery team will visit each individual hospitalized or confined once a week. A non-billable note will be submitted into Sharenote to document the visit. If it is determined that visits are not appropriate the decision not to do so will be documented.

3. After the crisis has been resolved the assigned case manager will assist the individual/family in connecting with resources/supports that may assist to in limiting or resolving future crisis situations.

III. TRAINING AND SUPERVISION OF CASE MANAGERS:

A. All case managers will be trained in:
    1. The National Alliance for Direct Support Professionals (NADSP) 15 Competency Areas (Annex - 21.17a). Case Manager Supervisors will adhere to the National Frontline Supervisor Competencies. (Annex - 21.17b).
    2. Columbia-Suicide Severity Rating Scale (C-SSRS).

Background

Recovery is cited, within *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, as the "single most important goal" for the mental health service delivery system.

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings.

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The 10 Fundamental Components of Recovery

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Components of Recovery

Resources
www.samhsa.gov
National Mental Health Information Center
1-800-789-2647, 1-866-889-2647 (TDD)

NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Psychiatric Rehabilitation Association

Growing and Training the Recovery Workforce

PRINCIPLES OF MULTICULTURAL
PSYCHIATRIC REHABILITATION SERVICES
Executive Summary

PRA recognizes the striking disparities in mental health care found for cultural, racial and ethnic minorities in the USA, and endorses these ten principles as the foundation for providing effective multicultural psychiatric rehabilitation services. This endorsement supports recommendation regarding multicultural diversity published in the Mental Health: A Report of the Surgeon General (1999) *and* Mental Health: Culture, Race, Ethnicity: Supplement to Mental Health: Report of the Surgeon General (2001).

Principle 1: Psychiatric rehabilitation practitioners recognize that **culture is central, not peripheral, to recovery**, as culture is the context that shapes and defines all human activity.

Principle 2: Psychiatric rehabilitation practitioners study, understand, accept, and appreciate their own cultures as a basis for relating to the cultures of others.

Principle 3: Psychiatric rehabilitation practitioners **engage in the development of ongoing cultural competency**, in order to increase their awareness and knowledge, and to develop the skills necessary for appropriate, effective cross-cultural interventions.

Principle 4: Psychiatric rehabilitation practitioners recognize that **thought patterns and behaviors are influenced by a person's worldview, ethnicity and culture** of which there are many. Each worldview is valid and influences how people perceive and define problems; perceive and judge the nature of help given; choose goals; and develop or support alternative solutions to identified problems.

Principle 5: Psychiatric rehabilitation practitioners recognize that discrimination and oppression exist within society; these take many forms, and are often based on perceived differences in color, physical characteristics, language, ethnicity, gender, gender identity, sexual orientation, class, disability, age, and/or religion. Psychiatric rehabilitation practitioners play an active role and are **responsible for mitigating the effects of discrimination associated with these barriers** and must advocate, not only for access to opportunities and resources, but also for the elimination of all barriers that promote prejudice and discrimination.

Principle 6: Practitioners **apply the strengths/wellness approach to all cultures**.

Principle 7: Psychiatric rehabilitation practitioners show respect towards others by **accepting cultural values** and beliefs that emphasize process **or** product, as well as harmony **or** achievement. They demonstrate that respect by appreciating cultural preferences that value relationships and interdependence, in addition to individuality and independence.

Principle 8: Psychiatric rehabilitation practitioners accept that **solutions to any problem are to be sought within individuals, their families (however they define them), and their cultures**. The person using psychiatric rehabilitation services and his/her family are sources of expanding the practitioner's knowledge about that culture, how to interpret behaviors, and how to integrate these cultural perspectives into a rehabilitation/recovery plan. Alternatives identified by service providers are offered as supplementary or educational, rather than compulsory.

Principle 9: Psychiatric rehabilitation practitioners **provide interventions that are culturally syntonic**, and accommodate culturally determined strengths, needs, beliefs, values, traditions, and behaviors.

Principle 10: Psychiatric rehabilitation practitioners are responsible for **actively promoting positive inter-group relations**, particularly between the people who attend their programs and with the larger community.

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Psychiatric Rehabilitation Association
Growing and Training the Recovery Workforce

PRINCIPLES OF MULTICULTURAL PSYCHIATRIC REHABILITATION SERVICES

PRA recognizes the striking disparities in mental health care found for cultural, racial and ethnic minorities in the USA, and endorses these ten principles as the foundation for providing effective multicultural psychiatric rehabilitation services. This endorsement supports recommendation regarding multicultural diversity published in the Mental Health: A Report of the Surgeon General (1999) *and* Mental Health: Culture, Race, Ethnicity: Supplement to Mental Health: Report of the Surgeon General (2001).

Principle 1: Psychiatric rehabilitation practitioners recognize that **culture is central, not peripheral, to recovery**, as culture is the context that shapes and defines all human activity.

Every individual has a worldview and culture. Culture includes, for example, gender, gender identity, sexual orientation, race/ethnicity, level of ability/disability, age, religion/spirituality and socioeconomic status. Worldview refers to the essential truths and assumptions on which interactions with others and reactions to events are based. Worldview determines a person's perceptions and understanding of his or her relation to spirituality, humans, nature and the universe. Culture is a predominant force within worldview, shaping behaviors, values, and institutions. A culturally responsive psychiatric rehabilitation practitioner understands and appreciates that a person's strengths can be rooted in each person's culture, and that differences between people are to be appreciated as sources of enrichment that can expand the options available to solve problems. Psychiatric rehabilitation practitioners respect the unique, culturally-defined needs of all individuals, and believe that diversity within cultures is as important as diversity between cultures. Psychiatric rehabilitation practitioners also recognize that each individual is unique and has retained varied aspects of the beliefs, traditions, and values of his or her culture(s) of origin, although an individual may or may not accept those beliefs, traditions, and values. In addition, any individual may have assimilated or acculturated to the dominant culture to a greater or lesser degree. Factors related to a person's country of origin and immigration, and that of his or her family, impact understanding and acceptance of the dominant culture, whether that immigration or migration was recent or distant.

Principle 2: Psychiatric rehabilitation practitioners study, understand, accept, and appreciate their own cultures as a basis for relating to the cultures of others.

The essence of multiculturalism is the study of one's own culture and ethnicity as the basis for understanding and identifying with those from others. Interpersonal encounters are not "objective" or "value-free" even when these encounters occur in a therapeutic or rehabilitation relationship. In many cultures, encounters and experiences influence simultaneously the mind, body, and spirit, creating both objective and subjective effects. The insights, suggestions, and approaches offered by a psychiatric rehabilitation practitioner arise naturally from the practitioner's personal beliefs, values, and social positions. Psychiatric rehabilitation practitioners need to be aware of their own worldviews, ethnicities and cultures and how these affect their approaches to providing rehabilitation and recovery-oriented services. Psychiatric rehabilitation practitioners may know intellectually about the importance of preventing their own biases from interfering with their ability to work with people in recovery. However, psychiatric rehabilitation practitioners also need to appreciate their own culture as a basis for forming partnerships with people in recovery. Psychiatric rehabilitation practitioners also accept that their own identities are complex and contain aspects of cultures with which they have interacted.

Principle 3: Psychiatric rehabilitation practitioners **engage in the development of ongoing cultural competency**, in order to increase their awareness and knowledge, and to develop the skills necessary for appropriate, effective cross-cultural interventions.

Psychiatric rehabilitation practitioners need to be committed to learning about problems and issues that adversely and disproportionately affect the various cultural groups with whom they work. They must recognize that every human encounter is a cross-cultural encounter, as no two individuals have identical experiences and backgrounds. Cultural

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competency training provides more than information about individual cultures; it provides ongoing opportunities for personal exploration and developing self-awareness. In addition, cultural competency training goes beyond a focus on providing services to individuals, but considers cultural competence within supervision, at the program and organizational levels, and throughout the larger service system.

Principle 4: Psychiatric rehabilitation practitioners recognize that **thought patterns and behaviors are influenced by a person's worldview, ethnicity and culture** of which there are many. Each worldview is valid and influences how people perceive and define problems; perceive and judge the nature of help given; choose goals; and develop or support alternative solutions to identified problems.

Individuals who use psychiatric rehabilitation services are recognized as the drivers of the rehabilitation process, and choose their own goals. Psychiatric rehabilitation assessments examine strengths and needs relative to achievement of those person-centered goals. Psychiatric rehabilitation practitioners routinely include an exploration of an individual's worldview as part of the process of psychiatric rehabilitation, recognizing that this worldview will influence the selection of personal goals and the commitment to achieving them. Any person from a non-mainstream cultural/ethnic group has to be bicultural to succeed in the mainstream culture, and psychiatric rehabilitation practitioners recognize that this bicultural stance, along with demands to acculturate, creates its own set of mental health issues and identify conflicts. People's relationships to their reference group, along with their personal satisfaction, goals, and comfort need to be considered when they are making choices influenced by cultural identity, whether that identify be mono- or multi-cultural.

Principle 5: Psychiatric rehabilitation practitioners recognize that discrimination and oppression exist within society; these take many forms, and are often based on perceived differences in color, physical characteristics, language, ethnicity, gender, gender identity, sexual orientation, class, disability, age, and/or religion. Psychiatric rehabilitation practitioners play an active role and are **responsible for mitigating the effects of discrimination associated with these barriers** and must advocate, not only for access to opportunities and resources, but also for the elimination of all barriers that promote prejudice and discrimination.

Stigmatization, rejection, and discrimination must be addressed as rights violations, as well as barriers to the attainment of health and full participation in society and community. Every defined population group and every individual has unique, culturally defined needs and strengths. Psychiatric rehabilitation practitioners understand that people who use psychiatric rehabilitation services are usually best served by persons who are part of or are aware and knowledgeable of that culture, while recognizing that membership in a particular cultural group does not, in itself, create competence as a practitioner. In order to ensure the inclusion of all, psychiatric rehabilitation practitioners need to actively engage in their programs people from diverse backgrounds that reflect the demographics of the community served. In addition, it is a moral and ethical obligation of psychiatric rehabilitation practitioners to combat discrimination, to advocate for inclusiveness, and to remove barriers to service use.

Principle 6: Practitioners **apply the strengths/wellness approach to all cultures**.

Culturally competent psychiatric rehabilitation practitioners understand and appreciate that individuals' strengths are often based in their cultures, and that each culture has its own values for defining wellness. For many people, culture can give warmth, security, and a sense of belonging and identity, although this may not be a universal experience. Psychiatric rehabilitation practitioners seek understanding of the positive and healthy contributions provided by a person's culture(s). Psychiatric rehabilitation practitioners function with the awareness that people's dignity is not guaranteed unless the dignity of their culture and people are preserved.

Principle 7: Psychiatric rehabilitation practitioners show respect towards others by **accepting cultural values** and beliefs that emphasize process **or** product, as well as harmony **or** achievement. They demonstrate that respect by appreciating cultural preferences that value relationships and interdependence, in addition to individuality and independence.

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Psychiatric rehabilitation has its origins in a Western humanistic worldview, based predominantly on United States and British culture. Most mental health service systems in the U.S. place a great deal of emphasis on outcomes, especially achievement of independence and success in role functioning, such as competitive employment. Psychiatric rehabilitation practitioners recognize that people who use psychiatric rehabilitation services will have a variety of definitions of what constitutes success, satisfaction, and recovery. Rather than relying on a single, standardized set of procedures and outcomes, psychiatric rehabilitation practitioners help create processes relevant to the individuals seeking services, and focuses on goals and outcomes that have meaning for those individuals, their families (as relevant), and their culture(s).

Principle 8: Psychiatric rehabilitation practitioners accept that **solutions to any problem are to be sought within individuals, their families (however they define them), and their cultures**. The person using psychiatric rehabilitation services and his/her family are sources of expanding the practitioner's knowledge about that culture, how to interpret behaviors, and how to integrate these cultural perspectives into a rehabilitation/recovery plan. Alternatives identified by service providers are offered as supplementary or educational, rather than compulsory.

Natural systems (e.g., family, community, church, healers) are the primary mechanisms of support for many individuals and populations. Individuals are served in various ways and to varying degrees by their natural system. To the extent desired by individuals, and accepted by their culture(s), these natural systems need to be active components in people's rehabilitation and recovery. When desired by the person receiving psychiatric rehabilitation services, practitioners start with the person's "family" as the primary and preferred point of interventions—with "family" being defined by that person's culture (i.e., nuclear, extended, and/or fictive [chosen]).

Principle 9: Psychiatric rehabilitation practitioners **provide interventions that are culturally syntonic**, and accommodate culturally determined strengths, needs, beliefs, values, traditions, and behaviors.

Racial, ethnic, and cultural factors play major roles in the expression of distress, help-seeking behaviors, and ways of understanding problems and psychiatric disabilities. Psychiatric rehabilitation programs and practitioners should strive to conduct all rehabilitation activities in the preferred communication style and language of consumers, their family members, and/or significant others. Treatment and rehabilitation modalities often need to be modified in order to be compatible with other factors, for example: family/group patterns and structures; communication, cognitive, behavioral, and learning styles; identity development; perceptions of illness; and help-seeking behaviors. Informed consent and individual choice also may require involvement of family members and significant others.

Principle 10: Psychiatric rehabilitation practitioners are responsible for **actively promoting positive inter-group relations**, particularly between the people who attend their programs and with the larger community.

An important principle of psychiatric rehabilitation is that of integration into the community. This principle applies not only to assisting individuals to become integrated into their communities of choice, but also to the integration of psychiatric rehabilitation programs into the surrounding communities. Involvement of persons who use psychiatric rehabilitation services, their families, significant others, and representatives from all communities served is needed to foster community integration and maximize access to services. Involvement in the program should be encouraged from community members, especially elders, leaders, and representatives of the diverse groups within the larger social context, while recognizing that one may need to reach far in order to get the needed expertise. Similarly, psychiatric rehabilitation practitioners should generate mechanisms for their programs to receive feedback and contribute to the communities that support them.

Resources

Mental Health: A Report of the Surgeon General (1999);

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http://www.surgeongeneral.gov/library/mentalhealth/home.html

Mental Health: Culture, Race, Ethnicity: Supplement to Mental Health: Report of the Surgeon General (2001); http://download.ncadi.samhsa.gov/ken/pdf/SMA-01-3613/sma-01-3613A.pdf

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Policy 21.18 – Peer Support Whole Health & Wellness

I. POLICY:

A. ACR offers a variety of the Peer Support services to assist individuals throughout their recovery process. A key focus of ACR is holistic care, ensuring that the individuals who participate in our treatment programs receive the necessary treatment, referrals and/or linkages to address all of the individual's recovery needs to include but not limiting: mental health, physical health, social, substance abuse, housing, employment and other needs that are impacting on an individuals recovery and interfering with the individual's sense of wellness. ACR has developed a treatment approach that focuses on the care of the whole person, body, mind, spirit, community, and their interactions with society, in other words Whole Health and Wellness.

B. The goal of ACR's Peer Support Whole Health & Wellness is to promote healthy lifestyles for individuals with mental and behavioral health issues. Whole Health and Wellness is a to a treatment approach that focuses on the care of the whole person, body, mind, spirit, community and their interactions with society. Central to this program is the a focus on the 10 Whole health and resiliency factors:

1. Stress Management
2. Healthy Eating
3. Physical Activity
4. Restful Sleep
5. Service to Others
6. Support Network
7. Optimism Based on Positive Expectations
8. Cognitive Skills to Avoid Negative Thinking
9. Spiritual Beliefs and Practices
10. A Sense of Meaning and Purpose

C. Here ACR we believe in looking at the individual as a whole, providing integrated healthcare to treat the whole health of persons served. We work side by side to create healthy life styles and a better overall quality of life for us all. We believe each individual should have opportunities to choose and pursue their own goals. It is our responsibility to provide the needed supports and services allowing this to happen. Our objective is to help the people we serve integrate into the community and increase the control they have over their lives and activities. We encourage each individual to develop skills and supports necessary to prevent relapse and re-hospitalization.

II. PROCEDURES:

A. Peer Support Whole Health and Wellness is a specialized program that assist/encourages individuals with medical needs, health deficiencies and concerns to overcome these deficits with the hope of improving the individual's overall quality of life. Individuals admitted into this program:

1. Must have two co-existing serious health conditions (hypertension, diabetes, obesity, cardiovascular issues, pulmonary issues, etc.), one of which is a mental health condition; and one or more of the following:
    a. Individual requires and will benefit from support of Whole Health & Wellness Coaches (CPSs) for the acquisition of skills needed to manage health symptoms and utilize/engage community health resources; or
    b. Individual may need assistance to develop self-advocacy skills in meeting health goals, engaging in health activities, utilizing community-health resources, and accessing health systems of care; or
    c. Individual may need peer modeling to take increased responsibilities for his/her own recovery and wellness.
2. Once admitted the individual is expected to participate in Peer Support Whole and Wellness Group once a week, and be seen by the WHAM CPS once weekly to track progress on the identified health goal. It also expected the individual will be seen by program nurse at least once a month.

B. Health engagement and health management for the individual are key objectives of the service.

C. The Whole Health & Wellness Coach (CPS) and supporting nurse also provide the following health skill-building and supports:
    1. Share basic health information which is pertinent to the individual's personal health.
    2. Promote awareness regarding health indicators.
    3. Assist the individual in understanding the idea of whole health and the role of health screening.
    4. Support behavior changes for health improvement.
    5. Make available wellness tools (e.g. relaxation response, positive imaging education, wellness tool boxes, daily action plans, stress management, etc.) to support the individual's identified health goals.
    6. Provide concrete examples of basic health changes and work with the individual in his/her selection of incremental health goals.
    7. Teach/model/demonstrate skills such as nutrition, physical fitness, healthy lifestyle choices.
    8. Promote and offer healthy environments and skills-development to assist the individual in modifying his/her own living environments for wellness.
    9. Support the individual as they practice creating healthy habits, personal self-care, self-advocacy and health communication (including but not limited to disclosing history, discussing prescribed medications, asking questions in health settings, etc.).
    10. Support the individual to identify and understand how his/her family history, genetics, etc. contribute to their overall health picture.
    11. Support the individual in understanding medication and related health concerns
    12. Promote health skills such as:
        a. Physical Fitness
        b. Healthy choices
        c. Nutrition
        d. Healthy meal preparation
        e. Teaching early warning signs/symptoms which indicate need for health intervention, etc.

D. Specific interventions may also include:

1. Supporting the individual in being able to have conversations with various providers to access health support
2. Treatment and assisting individuals in gaining confidence in asserting their personal health concerns and questions,
3. Assisting the person in building and maintaining self- management skills.
4. Health should be discussed as a process instead of a destination.
5. Assist the individual to facilitate his/her active participation in the development of the Individualized Recovery Plan (IRP) health goals which may include but not be limited to:
    a. Attention to dental health
    b. Healthy weight management
    c. Cardiac health/hypertension
    d. Vision care
    e. Addiction
    f. Smoking cessation
    g. Vascular health
    h. Diabetes
    i. Pulmonary
    j. Nutrition
    k. Sleep disorders
    l. Stress management
    m. Reproductive health
    n. Human sexuality
    o. Other health areas.

E. These interventions are necessarily collaborative: partnering with health providers and partnering with the individual served in dialogues with other community partners and supporters to reinforce and promote healthy choices.

F. The Whole Health & Wellness Coach (CPS) will be partnered with the identified supporting nurse and other licensed health practitioners within ACR to access additional health support provided by ACR or to facilitate health referral and access to external health organizations.
    1. The Whole Health & Wellness Coach (CPS) is supported by a nurse.
    2. A monthly team meeting is held and documented during which the Whole Health & Wellness Coach/s and the designated RN/s convene to:
        a. Promote communication strategies.
        b. Discuss specific individual health trends.
        c. Consult on health-related issues and concerns.
        d. Brainstorm partnered approaches in supporting the person in achieving his/her whole health goals.

G. Expected outcomes should be consistent with those indicated in the individual's recovery/and wellness plan. These may include the following:
    1. Continued length of abstinence from substances
    2. Improved bio-psychosocial health
    3. Increased ability to identify and manage high-risk situations that could lead to relapse
    4. Increased ability to be proactive regarding relapse prevention and wellness recovery planning including

5. The ability to identify warning signs and triggers and to adhere to self-defined goals and strategies to
6. Maintain abstinence and wellness achievements
7. A reduction in mental illness and/or substance use disorder services as individuals assume responsibility for their own wellness and recovery stability manage and reduce their symptoms through varied self-help techniques and initiate the support of a network of peer indigenous community and professional supports
8. Increase in stable housing and employment
9. Increased linkages made to other recovery and wellness support services
10. Improved overall quality of life.

H. The Peer Support Whole and Wellness Program is fully integrated with all of ACR adult programs except for Assertive Community Treatment. Is fully expected that other ACR program staff will refer individuals with health issues/concerns and who meet the program admission criteria for the Peer Support Whole and Wellness Program. Once admitted into the Peer Support Whole and Wellness Program treatment goals, interventions will be developed and added the Individual Recovery Plan (IRP).

III. TRAINING:

A. The CPS Wellness and Recovery Coach must have successfully the DBHDD Whole Health Action Management (WHAM) Training Program.
B. Clinical Director, Supervisory Staff and nurses will be trained using the Supervisor Guide: Peer Support Whole Health and Wellness.

References:

- 21.18.a - Supervisor Guide: Peer Support Whole Health and Wellness
- 21.18.b -Whole Health Action Management Peer Support Training Participant Guide

Supervisor Guide:
Peer Support Whole Health and Wellness

This manual was developed as a resource for a Transformation Transfer Initiative (TTI) funded by National Association of State Mental Health Program Directors (NASMHPD). NASMHPD awarded a TTI grant to the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) to collaborate with the Georgia Mental Health Consumer Network

The following individuals contributed ideas and editorial comments.
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Table of Contents

Introduction

The Peer Support Whole Health and Wellness service is an important resource that can help people in recovery to lead a longer more satisfying life by promoting recovery, wellness, and healthy lifestyles; reducing identifiable behavioral health and physical health risks; and increasing the healthy behaviors that are likely to prevent disease onset. The Peer Support Whole Health and Wellness Coach is the practitioner trained to deliver this important new service. Practices conducive to effectively integrating Peer Support Whole Health and Wellness Coaches as staff of community behavioral health agencies include: a clearly defined job structure, adequate training, support and guidance regarding disclosure of peer status and personal experience, and opportunities for networking and social support. This manual contains information, resources, and strategies that supervisors and managers of community behavioral health agencies can use to successfully introduce the Peer Support Whole Health and Wellness service and the Wellness Coach role into the Georgia service delivery system.

The sections of this manual outline the essential foundations of the Peer Support Whole Health and Wellness Coach Role, including the scope of practice, key roles, responsibilities, and tasks. The purpose of supervision is discussed, along with the processes for setting up a relationship between the supervisor and the Peer Support Whole Health and Wellness Coach. Strategies for integrating the Coach into the team/agency culture and important supervision issues are highlighted. Quality improvement and program evaluation tools and processes are suggested to examine how well the Peer Support Whole Health and Wellness services promote healthy lifestyle goals and address personal and environmental obstacles to health care access. The final section highlights the importance and benefits of helping the peer providers in terms of personal and career development.

Section 1 Foundations of Peer Support Whole Health and Wellness

A large number of adults living with mental illnesses are becoming seriously ill and dying at a premature age, even while receiving support from the mental health system. These individual are living with chronic medical diseases that significantly shorten their lives. Many experience undiagnosed and/or untreated medical conditions that often lead to premature mortality and/or poor quality of life. A man supported by the public mental health system can expect to live to 53 years of age, whereas a woman can expect to live to 59. This represents a 25 year shorter average lifespan than the general population.

Many premature deaths are due to medical conditions such as cardiovascular disease, pulmonary disorders, and infectious diseases. The following are troubling conditions that affect the quality of life and quantity of years lived: circulatory disease, metabolic conditions (including diabetes), obesity, hyperlipidemia, osteoporosis, chronic pulmonary disease, HIV-related illnesses, and dental disease.

Of particular concern among this group of people is the occurrence of the metabolic syndrome. The *metabolic syndrome* is a cluster of symptoms that increases an individual's risk for diabetes mellitus and coronary heart disease[1]. These symptoms include abdominal obesity (increased waist circumference), elevated triglycerides, elevated high density lipoprotein cholesterol disorder, hypertension, and elevated fasting glucose.[1]

These serious health problems are frequently caused or worsened by lifestyle factors such as lack of physical activity, smoking, limited access to adequate healthcare and prevention services, poor diet and nutrition, substance abuse, and residence in group living situations with the consequent exposure to infectious diseases.

Peer specialist roles have been evolving, as people who have lived experience offer a potent resource to help other peers who are facing these health concerns through *education, support,* and *coaching*. Peer specialist roles evolved within the context of emerging "recovery-oriented" mental health system and Georgia has taken a leadership role with using peer specialists to focus on the whole health and wellness needs.

[1] Kelly, D. L., Boggs, D. L., & Conley, R. R. (2007). Reaching for wellness in schizophrenia. *Psychiatric Clinics of North America, 30*, 453-479.

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) was the first state to receive Medicaid Fee-for-Service reimbursement for Peer Support. Since that time, it has created a workforce of more than 1000 Certified Peer Specialists (CPSs) who have infused recovery principles into the traditional community mental health system. Beginning in 2007, Georgia began to consider health and wellness by introducing health/wellness into its Peer Support definition. In 2009, Georgia received a grant to create pilot programs for Peer Support Whole Health and, through this grant, demonstrated the positive impact that CPSs can have when working with individuals on developing motivation, setting goals and achieving positive outcomes.

The Georgia Mental Health Consumer Network (GMHCN) has been a partner throughout this policy conversation and has complemented this work using grants that have allowed Georgia consumers to have opportunities to learn about whole health through its annual Consumer Conferences. Since 2006, the Consumer Conference has had keynotes and learning tracks to promote healthy lifestyles and wellness. GMHCN has also been the recipient of Consumer Networking grants, which have supported Peer Support Whole Health, including the Self-Directed Recovery Project/Wellness Recovery Action Plan (WRAP) training, a peer wellness project that included introductory training to CPSs and individuals served regarding self-directed mind, body, spirit, and wellness; and the Georgia Peer Support Whole Health Resiliency Project, which is training CPSs and individuals served to consider resiliency factors and commitment to wellness goals.

The Peer Support Whole Health and Resiliency (PSWHR) training was developed in Georgia by Larry Fricks and Ike Powell of the Appalachian Consulting Group (ACG) in collaboration with the Georgia Mental Health Consumer Network (GMHCN) as part of a National Association of State Mental Health Program Directors (NASMHPD) Technology Transfer Initiative (TTI) grant. Some of the tools are adapted from the *Health and Recovery Peer Project* (HARP), based on the Chronic Disease Self-Management Program (CDSMP) developed at Stanford University and the *Relaxation Response* from the Benson-Henry Institute for Mind-

Body Medicine at Massachusetts General Hospital. PSWHR is a person-centered planning process that helps people with a mental health condition examine their health life-style; focus on their strengths, interests, and natural supports; and create and sustain personally defined healthier life-style habits and disciplines.

PSWHR is built on the premise that people should not be forced or coerced to change their unhealthy lifestyle habits; rather they should be supported to examine their interests and strengths and to cultivate supports for long-lasting positive changes. Peers support peers to create new habits on a weekly basis to facilitate effective changes. PSWHR focuses on healthy eating and physical activity; restful sleep; stress management/relaxation response; spiritual beliefs, involving a sense of meaning and purpose and service to others; and developing a support network. PSWHR helps peers set and achieve a person-driven self-defined small achievable goal.

Additionally, the GMHCN and the Georgia DBHDD were instrumental in a national Pillars of Peer Support conference in 2011, organized to consider opportunities for Peer Support Whole Health and Resiliency. The leadership built upon the foundation of PSWHR. On June 6, 2012, the Centers for Medicare and Medicaid Services (CMS) approved Georgia as the first state to have Medicaid-recognized whole health and wellness peer support provided by certified peer specialists (CPSs). Georgia's newly approved Medicaid service, Peer Support Whole Health and Wellness, will be delivered by Peer Support Whole Health and Wellness Coaches certified in Whole Health Action Management (WHAM), a training developed by the Center for Integrated Health Solutions that promotes outcomes of integrated health self-management and preventive resiliency.

Section 2 Peer Support Whole Health and Wellness Scope of Practice[2]

Definition of Service: Peer Support Whole Health and Wellness is a service in which a Wellness Coach assists an individual with setting his/her personal expectations, introduces health objectives as an approach to accomplishing overall life goals, helps identify personal and meaningful motivation, and supports health/wellness self-management. The individual served should be supported to become the director of his/her health through identifying incremental and measurable objectives and action steps that make sense to the person and that can be used as a benchmark for future success.

Health engagement and health management for the individual are key objectives of the service. These should be accomplished by facilitating health dialogues; exploring the multiple choices for health engagement; supporting the individual in overcoming fears and anxiety related to engaging with health care providers and procedures; promoting engagement with health practitioners, including, at a minimum, participating in an annual physical; assisting the individual in finding a compatible primary physician who is trusted; and other engagement activities as needed.

Another major objective is promoting access to health supports. This is accomplished by using technology to support the individual's goals; providing materials that assist in structuring the individual's path to prevention, healthcare, and wellness; partnering with the person to navigate the health care system; assisting the person in developing his/her own natural support network that will then promote that individual's wellness goals; creating solutions with the person to overcome barriers that prevent healthcare engagement (e.g.,

[2] The content of this service as described in this manual is subject to change. Refer to the following link for updates: http://dbhdd.org/files/Provider-Manual-BH.pdf

transportation, food stamps, shelter, medications, safe environments in which to practice healthy choices, etc.); and linking the individual with other health and wellness resources (e.g., physical activity, fitness, healthy/nutritional food).

The Peer Support Whole Health and Wellness Coach and supporting nurse also provide the following health skill-building and supports:

- share basic health information that is pertinent to the individual's personal health;
- promote awareness regarding health indicators;
- assist the individual in understanding the idea of whole health and the role of health screening;
- support behavior changes for health improvement;
- make wellness tools available (e.g., relaxation response, positive imaging, education, wellness toolboxes, daily action plans, stress management, etc.) to support the individual's identified health goals;
- provide concrete examples of basic health changes and work with the individual in his/her selection of incremental health goals;
- teach, model, and demonstrate skills such as nutrition, physical fitness, healthy lifestyle choices;
- promote and offer healthy environments and skill development to assist the individual in modifying his/her own living environments for wellness;
- support the individual as s/he practices creating healthy habits, personal self-care, self-advocacy, and health communication (including, but not limited to, disclosing history, discussing prescribed medications, asking questions in health settings, etc.);

- support the individual to identify and understand how family history, genetics, etc. contribute to his/her overall health picture;
- support the individual in understanding medication and related health concerns; and
- promote health skills, considering fitness, healthy choices, nutrition, healthy meal preparation, teaching early warning signs/symptoms indicating a need for health intervention, etc.

Specific interventions may include supporting the individual in being able to have conversations with various providers to access health support and treatment and assisting individuals in gaining confidence in asserting personal health concerns and questions, while also assisting the person in building and maintaining self-management skills. Health should be discussed as a process instead of a destination.

Assistance will be provided to the individual to facilitate his/her active participation in the development of the Individualized Recovery Plan (IRP) health goals, which may include, but are not limited to, attention to dental health, healthy weight management, cardiac health/hypertension, vision care, addiction, smoking cessation, vascular health, diabetes, pulmonary function, nutrition, sleep disorders, stress management, reproductive health, human sexuality, and other health areas.

These interventions are necessarily collaborative and require partnering with health providers and partnering with the individual served in dialogues with other community partners and supporters to reinforce and promote healthy choices. The Peer Support Whole Health and Wellness Coach must also be partnered with the identified supporting nurse and other licensed health practitioners to access additional health support provided by the

organization or to facilitate health referral and access to medical supports external to the organization providing the Peer Support Whole Health and Wellness service.

The interventions are based upon respectful and honest dialogue supported by motivational coaching. The approach is strengths-based and involves sharing positive perspectives and outcomes about managing one's own health, what health looks like when the person gets there (visioning), assisting a person with re-visioning his/her self-perception (not as "disabled"), assisting the person in recognizing his/her own strengths as a basis for motivation, and identifying capabilities and opportunities upon which to build enhanced health and wellness. The peer-to-peer basis for the service allows the sharing of personal experience, including modeling wellness and offering mutual support that is also respectful of the individualized process and journey of recovery. This equality partnership between the supported individual and the Peer Support Whole Health and Wellness Coach should serve as a model for the individual as s/he then engages in other health relationships with health services practitioners. The identified nurse member of the team is in a supporting role to the Peer Support Whole Health and Wellness Coach.

A mind/body/spirit approach is essential to address the person's whole health. Throughout the provision of these services, the Peer Support Whole Health and Wellness Coach addresses and accommodates each individual's unique sense of culture, spirituality, and self-discovery, assisting individuals in understanding shared-decision making, and in building a relationship of mutual trust with health professionals.

Section 3 Peer Support Whole Health and Wellness Coach Skills and Ethics

Peer Support Whole Health and Wellness Coaches are trained in basic principles and skills and they are expected to follow a Code of Ethics. Many core skills are covered in the WHAM training manual.[3]

The following highlights six major Peer Support Whole Health and Wellness Coach skills:

- Engage in person-centered planning to identify strengths and supports in 10 science-based whole health and resiliency factors
- Support the person in writing a whole health goal based on personal motivation and person-centered planning
- Support the person in creating and logging a weekly action plan
- Facilitate WHAM peer support groups that create new health behaviors
- Build the person's Relaxation Response skills to manage stress
- Build the person's cognitive self-management skills to avoid negative thinking
- Consult with behavioral health nurses as necessary for technical medical advice and referral support

[3] http://www.integration.samhsa.gov/health-wellness/wham/WHAM_Participant_Guide.pdf

Certified Peer Specialist Code of Ethics

The following principles will guide Certified Peer Specialists in the various roles, relationships, and levels of responsibility in which they function professionally.

1. The primary responsibility of Certified Peer Specialists is to help individuals achieve their own needs, wants, and goals. Certified Peer Specialists will be guided by the principle of self-determination for all.
2. Certified Peer Specialists will maintain high standards of personal conduct and conduct themselves in a manner that fosters their own recovery.
3. Certified Peer Specialists will openly share with consumers and colleagues their recovery stories from mental illness and will likewise be able to identify and describe the supports that promote their recovery.
4. Certified Peer Specialists will, at all times, respect the rights and dignity of those they serve.
5. Certified Peer Specialists will never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
6. Certified Peer Specialists will not practice, condone, facilitate, or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition, or state.
7. Certified Peer Specialists will advocate for those they serve that they may make their own decisions in all matters when dealing with other professionals.
8. Certified Peer Specialists will respect the privacy and confidentiality of those they serve.
9. Certified Peer Specialists will advocate for the full integration of individuals into the communities of their choice and will promote the inherent value of those individuals to those communities. Certified Peer Specialists will be directed by the knowledge that all individuals have the right to live in the least restrictive and least intrusive environment.
10. Certified Peer Specialists will not enter into dual relationships or commitments that conflict with the interests of those they serve.
11. Certified Peer Specialists will never engage in sexual/intimate activities with the consumers they serve.
12. Certified Peer Specialists will not abuse substances under any circumstance.
13. Certified Peers Specialists will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues.
14. Certified Peer Specialists will not accept gifts of significant value from those they serve.

Orienting people using services

The following statements might be included in an orientation by a Peer Support Whole Health and Wellness Coach for someone considering whether to use this service:

- When you work with a Peer Support Whole Health and Wellness Coach, you have someone who helps you focus on the goals you want to achieve and develop strategies to be sure you reach them. Peer support helps you take action in your life; so after each session you will apply what you learn and create something new in your career or in your life. With a Peer Support Whole Health and Wellness Coach, you will make clearer decisions and build a life that best matches who you really are. You gain clarity, focus and support to be the best you can be.

- As a Peer Support Whole Health and Wellness Coach, I partner with a peer to help deal with obstacles by choosing to emphasize strengths and focus on your overall wellness.

- When you work with a Peer Support Whole Health and Wellness Coach like me, you have someone who helps you focus on the goals you want to achieve and develop strategies to be sure you reach them.

- Whole Health and Wellness is about helping you to take *action* in your life; so after each session you will apply what you learn and create something new in your career or in your life.

Section 4 Peer Support Whole Health and Wellness Coach Roles and Responsibilities

The Peer Support Whole Health and Wellness Coach uses a set of strategies that engage, inspire, educate, and offer support to persons served in order to help them successfully set and work towards a health goal and connect to health services, including prevention, timely treatment, self -management, and follow-up. In order to be effective, a CPS needs certain core competencies—these allow the CPS to fulfill the key functions, roles, and responsibilities of a Peer Support Whole Health and Wellness Coach.

Core competencies include:

- Communication Skills
  - Competency in active listening and relationship-building
  - Ability to communicate with empathy and respect
  - Ability to bridge the communication gap between the health care system and the individual receiving the services
  - Ability to communicate orally and in writing
  - Ability to communicate with and facilitate dialogue between health care professionals, individuals, and their families

- Knowledge of and competence in Peer Support Whole Health and Wellness Services

- Knowledge and competence related to health and wellness resources in the community
  - Knowledge and ability to integrate health information into the culture and language of the community, including facts about prevention and management of disease and information about the health system
  - Ability to assist the individuals to use the health care system in a knowledgeable, empowered, and effective manner
  - Knowledge and ability to navigate the health care system

- Ability to actively participate as a member of a health-care team

Key functions include:

- Assist persons served in setting and achieving a goal related to wellness and a healthy lifestyle
  - share basic health information that is pertinent to the individual's personal health
  - promote awareness regarding health indicators
  - assist the individual in understanding the idea of whole health and the role of health screening
  - support behavior changes for health improvement
  - provide concrete examples of basic health changes and work with the individual in his/her selection of incremental health goals

- Support the individual as s/he practices creating healthy habits, personal self-care, self-advocacy, and health communication (including but not limited to disclosing history, discussing prescribed medications, asking questions in health settings, etc.)

- Teach/model/demonstrate skills such as nutrition, physical fitness, healthy lifestyle choices

- Promote and offer healthy environments and skills-development to assist the individual in modifying his/her own living environments for wellness

- Support the individual to identify and understand how family history, genetics, etc., contribute to his/her overall health picture

- Promote health skills, considering fitness, healthy choices, nutrition, healthy meal preparation; and teach early warning signs/symptoms indicating a need for health intervention, etc.

- Make wellness tools available (e.g., relaxation response, positive imaging, education, wellness toolboxes, daily action plans, stress management, etc.) to support the individual's identified health goals; and

- Support the individual in understanding medication and related health concerns

Key roles and responsibilities include:

- Engage persons served to complete an assessment of physical wellness strengths
- Assist the individual in understanding whole health and the role of health screenings
- Support individual to coordinate primary care physician visits and other medical appointments such as screening clinics, diagnosis centers, tech labs, and allied health services
- Assist in arranging transportation to and from medical services and in accessing and maintaining insurance coverage (collect medical, financial, and other forms that are necessary for health care access and services)
- Assist individual to coordinate care among providers, which may include facilitating communication with health care providers
- Provide wellness tools to the individual, based on needs and personal preferences
- Provide emotional support to alleviate fears of and barriers to accessing quality health care
- Motivate and educate individuals and their family/caregivers about the importance of preventive services
- Employ strategies to engage peers who have challenges keeping important follow-up appointments to identify barriers and obstacles, and collaborate to find solutions
- Link peers to community-based support services
- Serve as a resource and wellness champion to the team to support and encourage access to health education and wellness promotion activities, resources, strategies, and tools
- Share basic health information pertinent to the individual's personal health
- Promote awareness regarding health indicators
- Regularly attend and participate in team meetings

Key outcomes indicating success:

Because the overall aim of Peers Support Whole Health and Wellness services is to help remove personal and environmental obstacles to health care access, individuals receiving this service should demonstrate the following outcomes:

- Improved access to treatment and self-care for medical conditions
- Decrease in use of emergency room services
- Decrease in symptoms of physical illnesses
- Regular physicals and follow through with medical and dental appointments
- Increased adherence to agreed-upon protocols, medication regimens, and/or wellness strategies
- Increase in the knowledge of the person served about his/her health conditions
- Increase in the knowledge of the person served about how to manage his/her physical and behavioral health conditions
- Increase in knowledge and use of prevention activities by the person served
- Improved feelings of wellness and improved quality of life indicators
- Increase in knowledge of the healthcare system(s)

Quality improvement

By developing quality improvement indicators and plans, organizations will be able to capture the outcomes and impacts of the Peer Support Whole Health and Wellness service. Documented outcomes provide value to the organization so it can justify continued funding and communicate successes to stakeholders. In addition, service providers experienced continued enthusiasm for their work when they have clear evidence of their effectiveness. The most basic indicator might be satisfaction survey data (see example on next page).

The **Peer Support Whole Health and Wellness Service Satisfaction Survey is a** 13-question survey consisting of 11 questions scored on a 5-point Likert-type scale, followed by two open ended questions (Swarbrick, 2013). This survey may be used without cost, provided the citation is included on the reprinted page.

Peer Support Whole Health and Wellness Service Satisfaction Survey[4]

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. My Peer Support Whole Health and Wellness coach treats me with courtesy, compassion, and respect.	1	2	3	4	5
2. My Peer Support Whole Health and Wellness coach treats me as a person, and helps me see my strengths objectively.	1	2	3	4	5
3. My Peer Support Whole Health and Wellness coach treats me as a person, and helps me see my challenges and concerns objectively.	1	2	3	4	5
4. My Peer Support Whole Health and Wellness coach communicates clearly when we are speaking.	1	2	3	4	5
5. My Peer Support Whole Health and Wellness coach paces the sessions so we remain accountable to reviewing goals, progress, and new steps.	1	2	3	4	5
6. My Peer Support Whole Health and Wellness coach effectively helps me review my personal strengths and areas for improvement.	1	2	3	4	5
7. My Peer Support Whole Health and Wellness coach is there to help me work on my concern as I see it, not his/her idea of what I need to work on.	1	2	3	4	5
8. My Peer Support Whole Health and Wellness coach helps me brainstorm ideas, problem solve and rarely offers advice.	1	2	3	4	5
9. My Peer Support Whole Health and Wellness coach is reliable with keeping appointment times, carrying out any "assignments," etc.	1	2	3	4	5
10. My Peer Support Whole Health and Wellness coach helps me stay accountable to myself and my wellness plan.	1	2	3	4	5
11. My Peer Support Whole Health and Wellness coach Peer Support Whole Health and Wellness coach is someone I would recommend to others.	1	2	3	4	5

12. Please share the most important benefit you got out of working with your Peer Support Whole Health and Wellness Coach:

13. Please share anything else you would like regarding your experience working with your Peer Support Whole Health and Wellness Coach:

[4] Adapted from Swarbrick, M. (2013) *Wellness Coaching Satisfaction Survey*. CSPNJ Institute for Wellness and Recovery Initiatives.

Various health and wellbeing processes and tools might be used for quality improvement or program evaluation planning (see Appendix B). For example:

- **The Duke Health Profile** is a 17-item questionnaire tool that has been in use since 1990, and is supported by over 60 articles in the peer-reviewed literature. Scoring supports sub-scaling for physical health, mental health, social health, general health, perceived health, self-esteem, anxiety, depression, anxiety depression, pain, and disability.

- **The Patient Activation Measure (PAM)** is a 13-item questionnaire supported by nearly 40 articles in the peer-reviewed literature. It is designed to assess individual's knowledge, skill, and confidence for personal healthcare self-management

- The **World Health Organization Quality of Life** (WHOQOL-BREF) instrument is comprised of 26 items that measure the following four broad domains: physical health, psychological health, social relationships, and environment. http://www.who.int/substance_abuse/research_tools/en/english_whoqol.pdf

Domain	*Facets incorporated within domains*
1. Physical health	Activities of daily living Dependence on medicinal substances and medical aids Energy and fatigue Mobility Pain and discomfort Sleep and rest Work Capacity
2. Psychological	Bodily image and appearance Negative feelings Positive feelings Self-esteem Spirituality / religion / personal beliefs Thinking, learning, memory, and concentration
3. Social relationships	Personal relationships Social support Sexual activity
4. Environment	Financial resources Freedom, physical safety, and security Health and social care: accessibility and quality Home environment Opportunities for acquiring new information and skills Participation in and opportunities for recreation / leisure activities Physical environment (pollution / noise / traffic / climate) Transport

Metabolic risk factors can be tracked using various forms. The following is an excellent monitoring tool: http://www.cqaimh.org/pdf/tool_metabolic.pdf

Quality improvement and program evaluation efforts could also focus on specific health indicators. The following two pages provide sample questions that may be asked at certain intervals. For example, these questions might be asked when a person first begins to work with a Peer Support Whole Health and Wellness Coach. Following the first meeting, the questions might be asked at various intervals to determine whether people are receiving the services they need and want, and whether their access to health care has improved as a result of working with the Peer Support Whole Health and Wellness Coach.

1. **Have you ever been told by your doctor or health professional that you have or had one or more of these conditions?**(check all that apply)

____Diabetes	____Stroke
____Asthma	____High cholesterol
____Angina or coronary artery disease	____Anemia
____High Blood Pressure	____Heart Attack

Other (list)_____

2. **In the last 12 months, about how many times did you see your medical doctor or health provider in an office or outpatient setting for a <u>physical health problem</u>?**

3. **In the last 12 months, about how many times did you use an emergency room for <u>physical health problems</u>?**

4. **Was there a time in the past 12 months when you needed medical care but could not get it?**

Circle one:	YES	NO

5. **Would you say that in general your health is**

Circle one:	Excellent	Very Good	Good	Fair	Poor

6. **Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your <u>physical health NOT good</u>?**

Circle one: 0 days	1-5 days	6-10 days	11-15 days	16-20 days	21-30 days

7. **Thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your <u>mental health NOT good</u>?**

Circle one: 0 days	1-5 days	6-10 days	11-15 days	16-20 days	21-30 days

8. During the past 30 days, for how many days did <u>poor physical health</u> keep you from doing your usual activities, such as self-care, work, or recreation?

Circle one: 0 days	1-5 days	6-10 days	11-15 days	16-20 days	21-30 days

9. During the past month, did you participate in any physical activities or exercise, such as running, a sport, gardening or walking for exercise?

Circle one:	YES	NO

10. Do you smoke? (*check one*)

_____No, I have never smoked
_____No, but I used to
_____Yes, but I want to quit
_____Yes, and I am not currently considering quitting

Section 5 Supervision

Effective supervision is critical for successful employment of persons in recovery, as it is for any worker. Supervising people with disabilities is, in most ways, exactly like supervising people without disabilities. After recruiting, hiring, and orienting a new employee, any ongoing issues can be readily addressed in supervision, such as job and role clarification, expectations, and performance; confidentiality; disclosure; dual roles; and working as a team member[5].

Supervision is a dynamic process by which a worker who has direct responsibility for carrying out a program in an agency is helped by a designated responsible staff person to make the best use of knowledge and skills so as to perform the requirements of the position effectively. In this context, the purpose of supervision is to help the Peer Support Whole Health and Wellness Coach to be resourceful and effective in performing his/her work duties and effectively fulfilling the requirements and duties of the position.

Supervision works well as a reflective process whereby the supervisor helps the Peer Support Whole Health and Wellness Coach to examine his or her performance and continue to develop and refine his or her abilities to perform all required duties as effectively as possible. In order to accomplish this, both the supervisor and the Peer Support Whole Health and Wellness Coach need clear expectations. Therefore, a *position description* or *job description* should be provided, and clear performance evaluation reviews should be performed at pre-determined intervals. Appendix C outlines elements of a good job description.

[5] Gates, L., & Akabas, S. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration Policy Mental Health and Mental Health Service Research, 34,* 293-306.

The supervisor is responsible for creating an environment for learning and growth. The following supervisory tasks are used to accomplish this goal:

Supervisory Tasks
• Fully understand the unique role of the Peer Support Whole Health and Wellness Coach and the CPS Code of Ethics • Create a supportive environment in which the Peer Support Whole Health and Wellness Coach is encouraged to learn and develop the capacity to apply and refine skills • Promote a stimulating environment that involves questioning and reflective practice • Help the Peer Support Whole Health and Wellness Coach to identify strengths and areas for growth • Assist the Peer Support Whole Health and Wellness Coach to set professional goals to develop and refine skills and abilities • Treat the Peer Support Whole Health and Wellness Coach with the respect due to any other mature responsible adult • Give regular constructive feedback, including highlighting strengths, and • Actively request-feedback from the Peer Support Whole Health and Wellness Coach

Supervision ***is not*** support, but supervisors can provide supervision supportively. The supervisor can make the Peer Support Whole Health and Wellness Coach feel comfortable in the work environment, so as to see it as a learning environment as well as a job. The effective supervisor will help the Peer Support Whole Health and Wellness Coach draw on personal experience and focus on developing relevant skills to meet the job requirements and to remain focused on the needs and preferences of the person served.

Supervisors in mental health and human service work are generally caring people who want to see a supervisee get help. It is important, due to workplace boundaries and privacy needs, not to address issues personally, but rather to follow company/agency policy and refer staff to an Employee Assistance Program (EAP) or outside service if a person is encountering health issues impacting the performance of work responsibilities. Even though the Peer Support Whole Health and Wellness Coach is known to be someone who has used mental health services, and the supervisor may be someone who has provided mental health services, it is not the job of the supervisor to address any personal or mental health issues, as this would create a stressful and unacceptable confusion of roles. Such a dual relationship would go against the Code of Ethics of most, if not all, helping professionals.

Supervision meetings often must address both administrative issues and reflective clinical issues relative to the ability of the Peer Support Whole Health and Wellness Coach to effectively work with persons served. The following are typical agenda issues for the supervision meeting:

- *Performance* - how things are going, what is working well, time management
- *Education/Growth* - skill development, sharing of resources, assistance with accessing resources, review of progress towards professional goals
- *Relationships* with co-workers
- *Management issues* - general agency policies and procedures
- *Personal Wellness* - any challenges getting in the way of performing duties or factors that can improve performance and wellness on the job

Peer Support Whole Health and Wellness Coaches may need to interact with health professionals, both ***alongside*** the people they serve, and sometimes on their behalf. An example of the latter is that a Peer Support Whole Health and Wellness Coach might ask a nutritionist whether a person's chosen diet sounds medically safe, or whether that person

needs help getting professional assistance. As a supervisor, together with your staff, you need to educate health professionals regarding:

- What the Peer Support Whole Health and Wellness Coach can and will do,
- The Peer Support Whole Health and Wellness Coach's role, which should not be overlapping or usurping the role of treatment professionals,
- The organization's commitment to using Peer Support Whole Health and Wellness Coach to support people served and improve outcomes, and
- Promoting how the Peer Support Whole Health and Wellness Coaches can and should be a valuable extension to their role.

In addition, both Peer Support Whole Health and Wellness Coaches and other health professionals need to operate on mutual respect. As the supervisor, you need to model and expect respect and cooperation.

Peer Support Whole Health and Wellness Coaches are members of a service delivery team who have defined responsibilities and roles, and who contribute to the bottom line of the team, which is providing efficient, effective, and appropriate services to service users. It is likely that maximum integration occurs when the Peer Support Whole Health and Wellness Coach is given clear and meaningful roles and responsibilities. Involving a Peer Support Whole Health and Wellness Coach in a meaningful role has the following advantages:

- Offers the team a special service from the lived experience of the Peer Support Whole Health and Wellness Coach,
- Increases the team members' sense of value and respect, and
- Sends a positive message to other team members regarding the belief in recovery and wellness.

Modeling is something that supervisors and colleagues all do, and probably will not be any different when supervising an employee who is assuming the Peer Support Whole Health and Wellness Coach role. Being professional, timely with deliverables, respectful of individuals, and respectful of oneself are characteristics that supervisors model for

supervisees and colleagues, which are not likely to change due to the presence of a Peer Support Whole Health and Wellness Coach. A Peer Support Whole Health and Wellness Coach is expected to arrive at work on time, meet deadlines, and be respectful—just like any other employee. Direct communication of job duties and expectation for the Peer Support Whole Health and Wellness Coach is essential, and represent good employment practice in general.

Peer practitioner employees are employees in a full sense. They should not be deprived of any participation offered to the other care providers on the team. Excluding Peer Support Whole Health and Wellness Coaches from a subset of team meetings, or from trainings open to all other team members, has the potential negative effects of demeaning the value of the Peer Support Whole Health and Wellness Coach, communicating disrespect, and perpetuating stigma.

Think of the "boundary" line for your supervision relationship, using the metaphor of a cell membrane. Some things need to pass through the cell membrane for the cell to stay alive, and other things need to be kept out or kept in. In order for this selective transmission to occur, the cell membrane is semi-permeable (some things pass through and some don't). Similarly, the boundary of the supervision relationship needs to keep some things in (e.g., the principle of confidentiality) and keep some things out (e.g., restricting the focus to exclude overly personal issues). However the "semi-permeable" metaphor goes only so far, as you cannot necessarily include or exclude whole classes of content, because the supervisee's stage of development, learning needs, and personal circumstances will influence your decision about what comes in and what goes out.

Content boundaries refer to the types of things that you deem eligible for discussion in supervision, whereas *process* boundaries refer to acceptable behaviors within the supervision relationship. Both sets of boundaries need to be clarified (minimally) at the beginning of a supervision relationship, as part of orienting the new supervisee.

The most obvious content boundary is deciding on the focus of supervision. Another type of content boundary is drawing the line between what is "supervision" and what is "therapy"—an easy conceptual distinction that can be difficult to draw in actual practice. Different theoretical models of counseling and supervision (e.g., behavioral vs. psychoanalytic) will draw this line in different places, and differences in placing this boundary also may exist across individuals, service organizations, professions, and academic training facilities. Regardless of where you, as the supervisor, draw this line, it needs to be explained fully to the new supervisee.

Most supervisors play multiple roles. Two roles are often seen as primary components of supervision in human services: administrative supervision and clinical supervision. These two roles are both complementary and contradictory. They are easy to distinguish in concept, but not so simple to disentangle in actual practice. Bradley and Ladany (2001)[6] distinguish the two as differing in emphasis, but being "closely linked in daily practice" (p. 5). Administrative supervision, they say, focuses on organizational efficiency, with all of the performance measures and required tasks implied by concentrating on the organization or agency. Clinical supervision, on the other hand, focuses on the person using services and on the developing relationship between the supervisee (in this case, the Peer Support Whole Health and Wellness Coach) and the person using services.

[6] Bradley, L.J., & Ladany, N. (2001). *Counselor supervision: Principles, process, and practice*. Philadelphia: Brunner-Routledge.

Again, the main role of a supervisor is to provide the Peer Support Whole Health and Wellness Coach with guidance and direction, not therapy, emotional support, or a waiver of job duties. A clear specific job description and an associated performance evaluation tool are critical for success. Job (or position) descriptions clarify the boundaries for the peer staff and the supervisor, and thereby should help the Peer Support Whole Health and Wellness Coach to competently perform duties and responsibilities. Expectations should be explicitly stated, recorded in writing by the supervisor, shared with the employee, and signed by both. The written job description and employment contract (if used) form the basis for structuring a supervision session and create the parameters for the relationship between the supervisor-and the Peer Support Whole Health and Wellness Coach. Appendix C includes key factors in creating a good *Job Description*.

Team members, such as the nurse and other professionals, need to be accessible to the Peer Support Whole Health and Wellness Coach as a source of information and practical guidance. The Peer Support Whole Health and Wellness Coach is trained in such skills as listening and building motivation, but may not have in-depth knowledge of health conditions such as diabetes or COPD. On occasion, the Peer Support Whole Health and Wellness Coach may have doubts about whether someone's medical care is adequate, about the potential side effects of treatment, or about the specifics of self-care and disease management for a particular condition. The team members need to be available as resources and supports, and should collaborate fully with the Peer Support Whole Health and Wellness Coach to provide services that are well-integrated, seamless, and effective.

Treatment team meetings should include the Peer Support Whole Health and Wellness Coach as a full member of the team. Information about treatment plans and issues

will be important for the Peer Support Whole Health and Wellness Coach, especially when working with an individual with complex medical needs. As someone who knows the person using services very well, the Peer Support Whole Health and Wellness Coach is in a position to share information about that person's values and preferences, about any cultural considerations, and about how those factors might be relevant to developing or implementing the IRP. Of course, the decision to share that information with the team is ultimately the decision of the person served, but many people working with a Peer Support Whole Health and Wellness Coach may appreciate this opportunity to provide information directly to the treatment team.

As a Certified Peer Specialist, the Peer Support Whole Health and Wellness Coach has an ethical responsibility to advocate for the person served. Supervisors and team leaders must understand and respect this, and ensure that the treatment team gives the attention and respect due to the Peer Support Whole Health and Wellness Coach. Collaboration and negotiation are key skills for all team members. Conflict may occur within the team, yet a healthy team not only tolerates but encourages conflict, as sharing opinions and disagreements are a sign of trust within the team.[7] While there are many sources of conflict and many barriers to conflict resolution that exist in the health care setting, effective conflict resolution strategies do exist, and can contribute to positive team relationships.[8]

The Peer Support Whole Health and Wellness Coach should be treated like any other employee, so it is expected that existing company/agency personnel policy, practices, and forms will meet these needs. The concept of universal design applies here. Universal design

[7] Lencioni, P. The trouble with teamwork. http://www.tablegroup.com/pat/articles/article/?id=5
[8] Brown, J., Lewis, L., Ellis, K., Stewart. M., Freeman, T. R., & Kasperski, M. J. (2011). Conflict on interprofessional primary health care teams—can it be resolved? *Journal of Interprofessional Care*, *25*, 4-10.

is the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. The following are universal design principles[9] as they relate to human resources policies and practices:

- *Equitable* - Relevant to all employees, regardless of position or background
- *Flexible* - Accommodates a wide range of needs
- *Simple and intuitive* - Easy to understand
- *Informative* - Explains how to implement the policy
- *Tolerance for error* - Minimizes misuse/abuse
- *Affordable* - Options provided are within budget

Reasonable accommodations may be needed by some individuals, but this does not mean waiving responsibilities. Rather, with such accommodations, an employee with a disability must be capable of doing all of the essential functions of the job. Supervisors may benefit from learning more about accommodations (see the next section).

The role of Peer Support Whole Health and Wellness Coach will be new to many people using services. Not only does the Peer Support Whole Health and Wellness Coach need to develop a sense of identity and confidence within the role, but s/he needs to be able to explain the role to professional colleagues, to external healthcare providers, to family members, and, most importantly, to persons served.

The supervisor plays a key role in Peer Support Whole Health and Wellness services. By attending to and supporting the professional development of the employees in the Wellness Coach role, supervisors contribute to both quality control and quality improvement. Supervisors influence organizational culture and contribute, for better or for worse, to employee morale and longevity on the job. A deep understanding of the Wellness Coach role will be essential to success.

[9] *adapted from UD Principles (Center for Universal Design, NC State University*

Section 6 Special Issues

Many common issues have been experienced by people in the field who have attempted to integrate peer providers into the staff of behavioral healthcare agencies and systems. Here are some frequently asked questions:

- When would it be considered crossing over the line of becoming the peer worker's personal therapist instead of his/her supervisor?
- What happens if you start receiving calls from the peer worker's therapist telling you that this job is destructive to his/her health?
- Is it OK, as the supervisor, to share my own personal information?
- What does it mean to be a role model/mentor while maintaining the integrity of the supervisory role?
- What about disciplinary action? When is it warranted?
- How do you set standards for reasonable accommodations for a peer worker when you have several working for you—all with different needs and backgrounds?

As stated in this manual, we strongly believe that supervising people living with a health condition or disability is very much like supervising people without disabilities. Supervisors and employees should be aware of the provisions of Title I of the American Disabilities Act (ADA), which require employers with 15 or more employees to provide qualified individuals with disabilities an equal opportunity to benefit from the full range of employment-related opportunities available to others. For example, the ADA prohibits discrimination in recruitment, hiring, promotions, training, pay, social activities, and other privileges of employment. It restricts questions that can be asked about an applicant's disability before a job offer is made, and it requires that employers make reasonable accommodation to the known physical or mental limitations of otherwise qualified

individuals with disabilities, unless it results in undue hardship. Basic elements of the protections of the ADA are that:

- Accommodations are individualized,
- Accommodations can be requested by an employee who discloses a disability, or can be proposed by an employer,
- There is no requirement for an employee to disclose a disability in advance of requesting an accommodation,
- Reasonableness tests are imposed, which generally rule out accommodations that cause undue hardship on the employer or change the essential nature of the job,
- Casual and common sense accommodations certainly can and should be sought at the front-line levels, and may not need the involvement of upper management and the personnel department, and
- Vocational rehabilitation professionals can play a role in developing accommodations, including job parsing and the selection, acquisition, and utilization of assistive technology.

Reasonable accommodations are an important part of good human resources practice, and also merit specific consideration. Offering accommodations can be very beneficial to agencies in retention of a well-performing employee. Flexibility and reasonable accommodations can improve the workplace and enhance staff motivation. These are generic accommodations that most good supervisors afford many employees (as with "universal design"), and benefit everyone, including those individuals who do not have a disclosed disability.

An employer resource on accommodations is the Job Accommodation Network, which provides information on job accommodations and the employment provisions of the ADA. A service of the Office of Disability Employment Policy, the Job Accommodation

Network[10] (JAN) provides free consulting for employers in order to expand employment opportunities for individuals with disabilities. They offer individualized worksite accommodation solutions and technical assistance with understanding and applying the ADA and other disability-related legislation. JAN also educates about self-employment and small business ownership opportunities for individuals with disabilities.

Ongoing communication about ethical areas and common ethical dilemmas encountered can avoid confusion and help a Peer Support Whole Health and Wellness Coach to perform the role effectively. Providing education focused on the agency code of ethics and support for adhering to the **Certified Peer Specialist Code of Ethics** (page 13 of this manual) is an important supervisory task. Establishing a clear position description and performance evaluation process can be the key to effectively supporting peer providers. Regularly scheduled supervision that focuses on competency and growth will form the basis of a supervisor-supervisee relationship that aims to empower Peer Support Whole Health and Wellness Coaches in their role. In addition, organizations may need to review and strengthen their human resource policies and practices in general, and ensure that policies related to confidentiality are applied consistently and fairly to employees who are persons in recovery.

Every employer should have clear-cut guidelines for when to refer an-employee to the Employee Assistance Program (EAP) or other counseling, and when employee behavior should result in a mandatory referral. Neither an employee's disclosed psychiatric condition nor a supervisor's mental health credentials and experience is an appropriate reason for counseling to be given in-house when it should be referred outside of the organization.

[10] See www.jan.wvu.edu Another useful resource is: http://cpr.bu.edu/resources/reasonable-accommodations/frequently-asked-questions-from-employers

Section 7 Career Development and Advancement

Ongoing education and training provide an excellent opportunity for peer providers to gain knowledge, skills, and support to contribute to the workforce effort to promote recovery, improved quality of life, and wellness. Learning does not stop after coursework is done or upon certification. Peer Support Whole Health and Wellness Coaches are expected to continually develop and refine the core skills: peer support, communications, coaching, and general knowledge of health, wellness, and available resources. Supervisors and administrators also should encourage peer providers to explore career development opportunities. Supervisors and administrators can provide a supportive environment where peer staff can grow personally and professionally.

As part of supervision and performance reviews, the Peer Support Whole Health and Wellness Coach should be encouraged to set goals and make plans for personal and professional advancement. Like most employees, most Peer Support Whole Health and Wellness Coaches will want to develop in their careers, both in-position (through developing and enhancing their skills and responsibilities) and potentially out-of-position (as they seek other positions in their current or other organizations to provide them challenge, satisfaction, increased responsibility, and increased compensation). Some peer providers have limited academic preparation. Pending regulatory changes, this may limit the positions they can hold in an organization. Others may have suitable credentials that might allow them to move quickly into other positions in the organization.

Peer Support Whole Health and Wellness Coaches, like all employees, have a reasonable expectation of being given the same career development support as any other employee. This includes inclusion in appropriate trainings, regular career development

reviews, tuition reimbursement, and any other career development support that their colleagues receive.

Like most employees, most peer providers want ***careers*** rather than ***jobs***. It is reasonable for such individuals to consider their current role of Peer Support Whole Health and Wellness Coach as only one in a continuum of positions in the field. At the organizational level, it will be necessary to ensure that reasonable career ladders and opportunities at all levels are extended to peer providers.

A subset of people taking on new peer practitioner roles may not adjust well to their roles at first. Some may need the kind of additional training or mentoring you could apply for any employee. Some many need employee supports that are more disability-oriented, such as intensive job coaching, job modification, or assistive technology. Some may need to develop the competence and confidence needed on the road for a highly mobile position, or additional education and training.

It is possible that a small subset of new Peer Support Whole Health and Wellness Coaches may not be able to adjust to the position, regardless of additional training and accommodation, and may need to be replaced. Prior to terminating the person, it is essential to ensure that all ordinary personnel policies are followed, and that the person has been given adequate information, opportunity, and support to succeed in the job. If termination becomes necessary, it is advisable to proceed in a way that leaves the door open for future re-application, should the person's future capabilities and interests suggest it is time to try again. Whenever possible, explore other position vacancies in your organization that might be a better match for the person's skills and aptitudes. In addition, it is essential to conduct a thorough assessment of the work environment and team performance to ensure that any

performance issues are not the result of a lack of role clarity or poor treatment and stigma from colleagues.

Some agencies are likely to hire Peer Support Whole Health and Wellness Coach staff in part-time roles. This may suit some employees, while others may not be satisfied with limited hours and limited compensation. Ideally, the amount of work for Peer Support Whole Health and Wellness Coaches will expand at the same rate as the Coaches are ready to expand their hours. While it is not the supervisor's role to deal with any benefits issues that may contribute to a person's unwillingness to work full-time, it is certainly acceptable to suggest benefits counseling.

In dealing with the challenges of helping a Peer Support Whole Health and Wellness Coach to integrate and grow, it may be useful for the supervisor to focus on the multiple benefits of doing so:

- As part of a wellness and recovery transformation, we need more peer providers throughout the mental health system,
- Service users and their family members benefit from seeing the successful activities of peer providers,
- Agencies needs competent and compassionate workers, and
- The individual who has joined your team wants and needs the job for financial and non-financial reasons.

Making a Peer Support Whole Health and Wellness *program* work requires the support of everybody involved, including:

- People served, who need to value the desired outcomes (health improvement), and be willing to take the time to work with the Peer Support Whole Health and Wellness Coach towards those outcomes,

- Professional and family/community supporters of the people you serve, who can obviously help increase or decrease acceptance by the person served,
- Other members of your team, who will play a key role both in creating referrals to the Peer Support Whole Health and Wellness Coach, and in providing him or her with practical support and a welcome place on a collaborative team,
- Your upper management and personnel department, who will help create the climate and secure the resources, and
- You, the supervisor, who will be the person to keep all of this going.

Clear communication will be an important part of sustaining or building increased use of a Peer Support Whole Health and Wellness Coach. It is entirely possible that people in all of the roles above have limited or no knowledge of the:

- impact that health and wellness factors are having on the lives and lifespan of people living with a mental and/or substance use disorder,
- extent to which these factors can be addressed, in part, through lifestyle changes, and
- increased prevalence of peer providers throughout the mental health system.

As a supervisor, you may find yourself conveying this information through a variety of means, such as staff trainings, articles in the organization's newsletters, or short talks at various get-togethers. You can help and encourage the Peer Support Whole Health and Wellness Coach to take on many of these activities in marketing the service.

Whether at your level and/or at an organizational level, changes in **processes** can play an important part.

- Are health assessments a part of all intakes?
- Should the results of some health assessments result in referral to your Peer Support Whole Health and Wellness Coach, or should the Wellness Coach be doing those assessments as part of every intake?

- Are the services of the Peer Support Whole Health and Wellness Coach considered a first-line choice for helping someone who is already using the agency's services deal with a lifestyle-related health or other wellness issue?
- Do your Peer Support Whole Health and Wellness Coaches speak regularly to your treatment groups, alumni groups, family groups, etc.?
- Does your new employee orientation include information about the services?
- Are Peer Support Whole Health and Wellness Coaches seen as an asset to aid not only the people you serve, but members of your workforce experiencing health or other wellness issues that could benefit from lifestyle change?
- Is an attention to wellness part of everything you do? Is your agency prepared to make cultural changes to support health and wellness?

Section 8: Summary

Wellness is both a service focus and a frame of mind. As the supervisor of a Peer Support Whole Health and Wellness Coach, you bring certain knowledge, attitudes, and expertise that you can use in this role. However, given that the role is relatively new, you will likely find that you have a lot to learn—about health promotion, about wellness coaching, about the advantages of employing peer providers, and about the many challenges faced by peer providers working within a mental health service system.

Peer Support Whole Health and Wellness services are built on the premise that people should not be forced or coerced to change their unhealthy lifestyle habits; rather they should be supported to examine their interests and strengths and to cultivate supports for long-lasting positive changes. The emphasis on strengths, on choice, and on continuously building on incremental successes provide a foundation for the service and represent a way of interacting with people using services that may be significantly different from how services have been provided in the past. Many mental health clinicians have been trained to focus on illness rather than wellness, and some may not believe that recovery is possible for people with significant mental health challenges. These discrepant perspectives can make the work environment especially challenging for the Peer Support Whole Health and Wellness Coach.

Your responsibility, as the supervisor, may need to go beyond professional development and guidance to one or more individual employees. You may find that your work must have a broader scope, including service provider education about the wellness coach role and about the need to attend to existing physical health concerns, disease prevention, and health promotion. You may need to do team building, to advocate for the Peer Support Whole Health and Wellness Coach, and to work closely with your human resources staff to ensure fair (and legal) treatment of valuable employees who may happen to have a disability.

As Georgia continues as an innovator and national leader in this important area, your role is critical—not only to your supervisees, but to the broader success of this initiative across the state and beyond.

Appendix A Summary of Medicaid State Plan Language[11]

The state plan includes the following CMS-approved definition elements.

Goal	To ultimately extend the members' lifespan by: • Promoting recovery, wellness, and healthy lifestyles • Reducing identifiable behavioral health and physical health risks • Increasing healthy behaviors intended to prevent disease onset • Lessening the impact of existing chronic health conditions
Interventions	• Supporting the individual in building skills that enable whole health improvements • Providing health support and coaching interventions about daily health choices • Promoting effective skills and techniques that focus on the individual's wellness self-management and health decision making • Helping individuals set incremental wellness goals and providing ongoing support for the achievement of those goals
Technical Elements	• Requires professional supervision in accordance with CMS-SMDL #07-011 • Requires a related goal(s) on the official treatment (recovery) plan • Requires health-related certification • Uses the WHAM training, which provides Peer Support and Whole Health and Wellness Coaches with six major skills to: 1. Engage in person-centered planning to identify strengths and supports in 10 science-based whole health and resiliency factors 2. Support the person in writing a whole health goal based on personal motivation and person-centered planning 3. Support the person in creating and logging a weekly action plan 4. Facilitate WHAM peer support groups which create new health behaviors 5. Build the person's Relaxation Response skills to manage stress • Build the person's cognitive self-management skills to avoid negative thinking • Allows Peer Support and Whole Health and Wellness Coach to provide the service with technical medical advice and referral support from behavioral health nurses, as necessary
Billing Detail	• HCPCS (Healthcare Common Procedure Coding System) Billing Code: Health and Wellness Supports, H0025 • Rate for 15 minute unit: Ranges from $15.13 to $24.36 depending on CPS experience and education and location of service

[11] This description is subject to change. Refer to the following link for updates: http://dbhdd.org/files/Provider-Manual-BH.pdf

Appendix B Quality Improvement/Evaluation Tools and Resources

Measurement of Health Status for People with Serious Mental Illnesses[12] is a report developed in 2008 jointly by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI, Inc.) and the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

This report was based on a relevant literature review, work-group meetings of the Medical Directors Council, and a two-day meeting of medical directors, peers in recovery, NRI researchers, SAMHSA representatives, academic researchers, and other technical experts. This report outlined suggestions for a standard set of health indicators that could be gathered regularly and used to inform the care as well as aggregated to provide population health data.

The report reviews how surveillance tools currently in use within the field of public health can be used for mental health surveillance. The report suggests that the following key indicators for data collection should include:

1. Personal History of Diabetes, Hypertension, Cardiovascular Disease and Pulmonary Disease
2. Family History of Diabetes, Hypertension, Cardiovascular Disease
3. Weight / Height / Body Mass Index (BMI)
4. Blood Pressure
5. Blood Glucose or HbA1C
6. Lipid Profile
7. Tobacco Use / History
8. Substance Use / History
9. Medication History / Current Medication List, with Dosages
10. Social Supports

[12] http://www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf

The Duke Health Profile[13] is a 17-item questionnaire tool that has been in use since 1990, and is supported by over 60 articles in the peer-reviewed literature. Scoring supports sub scaling for physical health, mental health, social health, general health, perceived health, self-esteem, anxiety, depression, anxiety depression, pain, and disability.

The profile form is included on the next page.

[13] Parkerson, G. R. Jr., Broadhead, W. E., and Tse, C. K. (1990). The Duke Health Profile. a 17-item measure of health and dysfunction. *Medical Care, 28, 11,* 1056-1072.

Duke Health Profile

INSTRUCTIONS: Below are some questions about your health and feelings. Please read each question carefully and place a check mark in the column which matches your best answer. You should answer the questions in your own way. There are no right or wrong answers.

	Yes, describes me exactly	Somewhat describes me	No, doesn't describe me at all
1. I like who I am.			
2. I am not an easy person to get along with.			
3. I am basically a healthy person.			
4. I give up too easily.			
5. I have difficulty concentrating.			
6. I am happy with my family relationships.			
7. I am comfortable being around people.			
TODAY would you have any physical trouble or difficulty:	None	Some	A Lot
8. Walking up a flight of stairs.			
9. Running the length of a football field.			

DURING THE PAST WEEK: How much trouble have you had with:	None	Some	A Lot
10. Sleeping.			
11. Hurting or aching in any part of your body.			
12. Getting tired easily.			
13. Feeling depressed or sad.			
14. Nervousness.			

DURING THE PAST WEEK: How often did you:	None	Some	A Lot
15. Socialize with other people (talk or visit with friends or relatives).			
16. Take part in social, religious, or recreation activities (meetings, church, movies, sports, parties).			

DURING THE PAST WEEK: How often did you:	None	1-4 Days	5-7 Days
17. Stay in your house, a nursing home, or hospital because of sickness, injury, or other health problem.			

The Patient Activation Measure (PAM)[14] is a 13-item questionnaire supported by nearly 40 articles in the peer-reviewed literature. It is designed to assess individual's knowledge, skill, and confidence for personal healthcare self-management.

Patient Activation Measure – 13 (responses are given on 1-100 scale)
1. When all is said and done, I am the person who is responsible for managing my health condition.
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function.
3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.
4. I know what each of my prescribed medications do.
5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.
6. I am confident I can tell my health care provider concerns I have even when he or she does not ask
7. I am confident that I can follow through on medical treatments I need to do at home.
8. I understand the nature and causes of my health condition(s).
9. I know the different medical treatment options available for my health condition.
10. I have been able to maintain the lifestyle changes for my health that I have made.
11. I know how to prevent further problems with my health condition.
12. I am confident I can figure out solutions when new situations or problems arise with my health condition.
13. I am confident that I can maintain lifestyle changes like diet and exercise even during times of stress.

[14] Hibbard, J. H., Mahoney, E. R., Stockard, J., & Tusler, M. (2005). Development and testing of a short form of the patient activation measure. *Health Services Research, 40, 6 Pt 1,* 918-1930.
Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. (2004). Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. *Health Services Research, 39, 4 Pt 1,* 1005-1026.

Appendix C Elements of a Good Job Description

A job description provides a summary of the primary duties, responsibilities, and qualifications of a position. It is important to reflect priorities and current expectations.

Components of the job description:

Function:
Summarize the main purpose of the position within the department/organization in one sentence.

Reporting Relationships
Describe the "chain of command" and the types of supervision the employee will get and will give, indicating the specific job titles of the supervisors and the positions supervised.

Responsibilities
List 4 to 6 core responsibilities of the position and identify several specific duties within each of the core responsibility areas.

Qualifications/Competencies

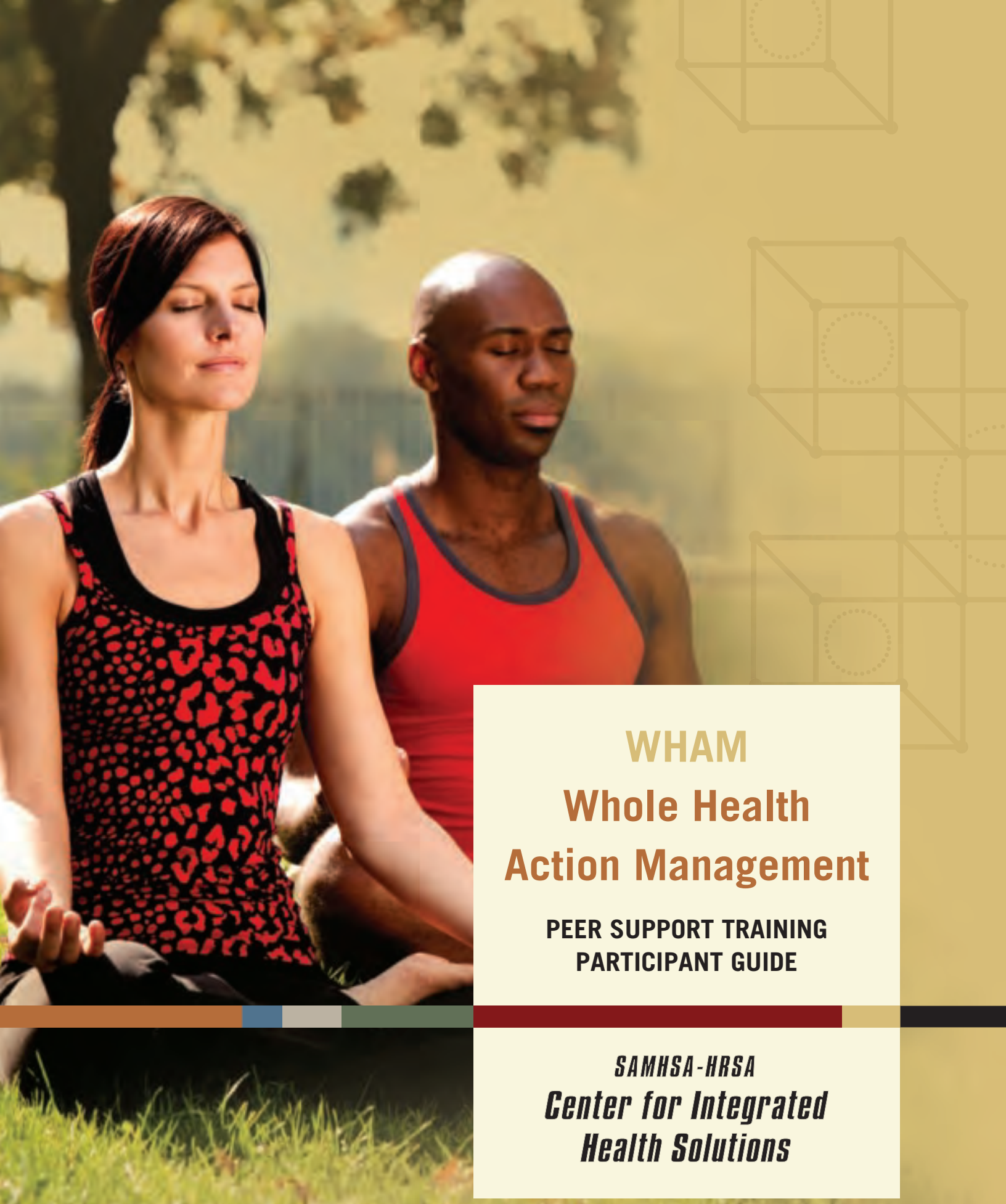
List required and preferred qualifications, credentials, and competencies in order of importance. These might include educational requirements (e.g., a high school diploma or equivalency), training or certification as a peer specialist, or specify that the employee must be a person in recovery (e.g., "Be a self-identified current or former user of mental health or co-occurring services who can relate to others who are now using those services").

Employment Conditions
Describe any relevant circumstances, such as any physical requirements (e.g., standing, lifting), environmental conditions, unusual work schedule (e.g., rotating shift, on-call hours), and any other requirements (e.g., driver's license, background check, random drug screen).

Tips from the Small Business Association[15] *(http://www.sba.gov):*

- A good job description begins with a careful analysis of the important facts about a job, such as tasks involved, methods used to complete the tasks, and the relationship of the job to other jobs.
- It's important to make a job description practical by keeping it dynamic, functional, and current.
- Don't get stuck with an inflexible job description! A poor job description will keep you and your employees from trying anything new and learning how to perform their jobs more productively. A well-written, practical job description will help you avoid hearing a refusal to carry out a relevant assignment because "it isn't in my job description."

[15] http://www.sba.gov/smallbusinessplanner/manage/manageemployees/SERV_JOBDESC.html



WHAM
Whole Health Action Management

PEER SUPPORT TRAINING PARTICIPANT GUIDE

SAMHSA-HRSA
Center for Integrated Health Solutions

TABLE OF CONTENTS

SAMHSA-HRSA

Center for Integrated Health Solutions

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

SAMHSA

www.integration.samhsa.gov

SESSION 1

Welcome and Introduction

About Us

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS offers technical assistance and resources for all those who are committed to addressing the complete healthcare needs of these individuals. CIHS is funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA).

Acknowledgements

The Whole Health Action Management (WHAM) Peer Support Training Participant Guide was designed for peers, by peers. A group of peers also generously volunteered their time to review and provide feedback on the guide. The SAMHSA-HRSA Center for Integrated Health Solutions is grateful to all of these peers, as well as to the following individuals for their support and contributions to developing the WHAM Participant Guide:

- Larry Fricks, CPS, Deputy Director, SAMHSA-HRSA Center for Integrated Health Solutions (Project Leader)
- Ike Powell, CPRP, Director of Training, Empowerment Partners, LLC
- Peggy Swarbrick, PhD, OT, CPRP, University of Medicine and Dentistry of NJ School of Health Related Professions, Department of Psychiatric Rehabilitation and Counseling Professions & Collaborative Support Programs of NJ

Recommended Citation

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About the Whole Health Action Management Peer Support Training

Welcome to the 2-day Whole Health Action Management (WHAM) Peer Support Training provided by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). The primary goal of this training and participant guide is to teach skills to better self-manage chronic physical health conditions, and mental illnesses and addictions — known as "behavioral health" — to achieve whole health. In the context of this training, whole health is defined as having a healthy mind and body.

A foundation of self-management in this training is peer support. In the United States, peer support traces back to as early as 1772 when Native Americans began forming social support groups to help people recover from alcohol use problems. With insight into the healing power of mutual support that shares lived experiences of hope and strength, they formed the first alcoholism recovery support groups. Group participants organized and solved their own issues, a process known as "self-management."[1]

Research in the field of physical health shows the considerable impact of peer support. For example, a Stanford Medical School study on breast cancer found that women who engaged in a weekly peer support group lived on average twice as long as the women who did not.[2]

What is the WHAM training and how does it leverage peer support? Let's say a person decides to go to a health center. Upon arrival, there are two entrances.

> The sign over Entrance A reads — "Enter here and we will explore with you all of the unhealthy aspects of your current lifestyle. Then we will help you identify the 3-4 unhealthy habits you have developed that have the most negative impact on your overall health. Once those are identified, we will work with you to create an action plan to change or break these unhealthy habits. You will have the opportunity to meet weekly with trained health professionals who will support you in this."
>
> The sign over Entrance B reads — "Enter here and we will explore with you your strengths, likes, interests, and what you see as possible in regard to creating and self-managing a healthier lifestyle. Then we will help you identify the healthy habits you would like to add in your life. And we will work with you to create an action plan, using your strengths, to develop new healthy habits. You will have the opportunity to meet weekly in a support group with your peers who are also working to improve and self-manage their whole health."

How would most people enter — through Entrance A or Entrance B? This training chooses Entrance B.

1. White WL. Slaying the Dragon: The History of Addiction Treatment and Recovery, Lighthouse Institute Publications, 1998.
2. Spiegel D et al. Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer, The Lancet, 1989.

There are two major components to the WHAM 2-day, 10-session training. The first component follows this Participant Guide and uses a person-centered planning process in 10 health and resiliency factors to help you create a concise whole health goal to begin the self-management process. The Participant Guide also provides learning skills to enhance self-management, including 8 weeks of WHAM peer support groups and a weekly action plan to create new health habits.

The WHAM training also focuses on developing mind-body resiliency to promote self-management skills. The 10 health and resiliency factors included in the training are recommended by the Benson-Henry Institute for Mind-Body Medicine at Massachusetts General Hospital, renowned for decades of research on promoting resiliency through stress reduction using the Relaxation Response. This training teaches the Relaxation Response as an essential resiliency self-management skill with research demonstrating that it is as predictable as medication in immediately reversing the stress-induced flight-or-fight response.

Mind-body resiliency skills and engagement in the healing relationships of peer support are also essential because of the growing awareness of the impact of trauma, especially childhood trauma, on all dimensions of health.

PARTICIPATION IN THE TRAINING MEANS YOU AGREE TO:

- ❍ Work on a whole health goal.
- ❍ Engage in peer support to reach your whole health goal.
- ❍ Participate in a WHAM peer support group that meets weekly for at least 8 weeks.

For financial sustainability, this training is also designed to teach participants skills to write a whole health goal in a concise format that could be added to a treatment plan.

Let's begin the journey through the WHAM Peer Support Training.

Note: Much of this Peer Support Training has been adapted from SAMHSA-funded Transformation Transfer Initiative Grants awarded to New Jersey and Georgia in 2009.

How to Use the WHAM Participant Guide

The WHAM participant guide is intended to help WHAM training participants set a concise whole health goal, learn skills for whole health self-management, and understand the "5 Keys to Success" (see page 6) for creating new health habits with a focus on facilitating a weekly WHAM peer support group. The guide is designed to engage participants in a process known as "person-centered planning." Person-centered planning is defined, in this training, as a process to support a peer in planning a whole health goal and reaching that goal with the intent of increasing self-management and independence. The person-centered planning process looks at current patterns, interests, and strengths in each of 10 health and resiliency factors.

There are four parts to the WHAM participant guide:

1. Session 1: Welcome and Overview
2. Sessions 2-6: Person-Centered Planning Process in 10 Whole Health and Resiliency Factors
3. Session 7: Health Risk, Screening, and Shared Decision Making
4. Sessions 8-10: 5 Keys to Success

The material in sessions 2-6 is designed like a workbook and can be presented in a variety of ways based on working as a group or one-to-one. If in a group setting, participants can take turns volunteering to read the content aloud to progress through the sessions, or the major points can be "lectured" by a WHAM Peer Support Group Leader. Regardless of the presentation format, there needs to be discussion about how each whole health and resiliency factor affects your physical and behavioral health.

Also, each area of health and resiliency outlined in this guide has a number of structured questions to help explore each area in relation to your lived experience. Those questions can be processed in a variety of ways:

- Each group member can write down their answers and then the leader can facilitate sharing those with the group.
- The group can work in pairs to share answers.
- The peer leader can practice one-to-one with a peer who may have writing challenges, asking the questions and then recording the answers for him or her.

Regardless of how the questions are processed, it is important to answer all the questions on pages 46-47.

BASIC COMPONENTS OF THE PARTICIPANT GUIDE

10 Whole Health and Resiliency Factors:

1 Stress Management

2) Healthy Eating

3) Physical Activity

4) Restful Sleep

5) Service to Others

6) Support Network

7) Optimism Based on Positive Expectations

8) Cognitive Skills to Avoid Negative Thinking

9) Spiritual Beliefs and Practices

10) A Sense of Meaning and Purpose

5 Keys to Success:

1) A Person-Centered Goal

2) A Weekly Action Plan

3) A Daily/Weekly Personal Log

4) One-to-One Peer Support

5) A Weekly WHAM Peer Support Group

The training is intended to teach the following whole health self-management skills:

- ❍ Engage in person-centered planning to identify strengths and supports in 10 science-based whole health and resiliency factors
- ❍ Write a whole health goal based on person-centered planning
- ❍ Create and log a weekly action plan
- ❍ Participate in WHAM peer support groups to create new health behavior
- ❍ Elicit the Relaxation Response to manage stress
- ❍ Engage in cognitive skills to avoid negative thinking

Notes:

PEER SUPPORT TRAINING SESSIONS

Session #1: Welcome and Overview

- ❍ Introduction
- ❍ 10 Health and Resiliency Factors
- ❍ Person-Centered Planning Process
- ❍ 5 Keys to Success

Session #2: The Science of Stress

- ❍ The Stress Response
- ❍ The Relaxation Response
- ❍ Stress Management

Session #3: Improving Your Health

- ❍ Healthy Eating
- ❍ Physical Activity
- ❍ Restful Sleep

Session #4: The Power of Human Connections

- ❍ Support Network
- ❍ Service to Others

Session #5: The Importance of Attitude

- ❍ Optimism Based on Positive Expectations
- ❍ Cognitive Skills to Avoid Negative Thinking

Session #6: Connecting With That Which Is More Than Self

- ❍ Spiritual Beliefs and Practices
- ❍ Sense of Meaning and Purpose

Session #7: Health Risk, Screening, and Shared Decision-making

- ❍ Health Risk
- ❍ Health Screenings
- ❍ Shared Decision-Making
- ❍ Health Screening Resources

Session #8: Key to Success 1

- ❍ Review and Prioritization
- ❍ Setting a Person-Centered Goal
- ❍ Applying the IMPACT Criteria

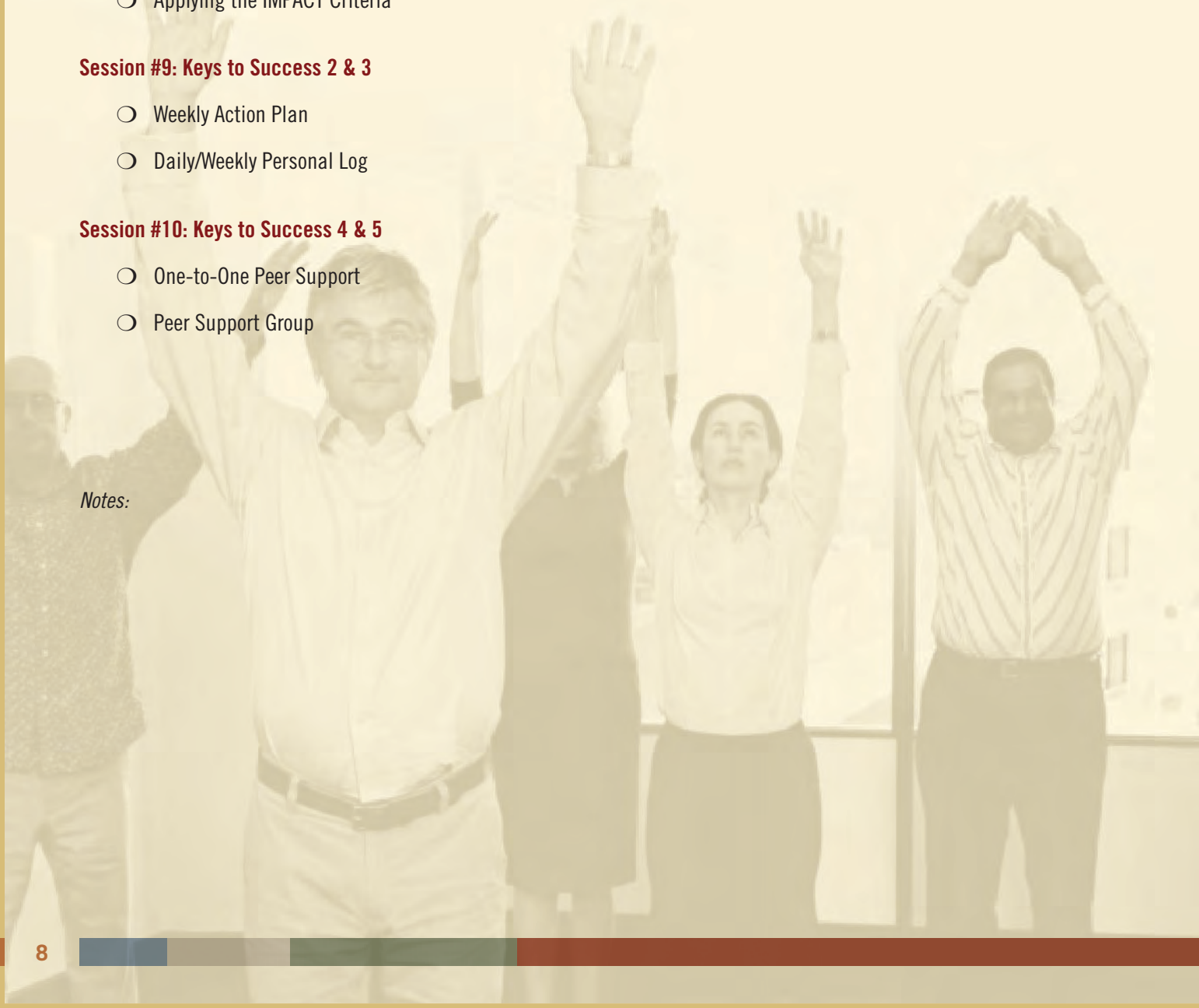
Session #9: Keys to Success 2 & 3

- ❍ Weekly Action Plan
- ❍ Daily/Weekly Personal Log

Session #10: Keys to Success 4 & 5

- ❍ One-to-One Peer Support
- ❍ Peer Support Group

Notes:



SESSION 2

The Science of Stress

- The Stress Response
- The Relaxation Response
- Stress Management

The Science of Stress

Stress is pervasive in American society. It is estimated that 60-80% of visits to healthcare providers in the U.S. are related to stress and its manifestations.[3] The prevention and treatment of the harmful effects of stress is a vital feature of health integration.

The body converts psychological stress into cellular stress that adversely affects the physical makeup of cells. This cellular stress is what uncovers our disease vulnerabilities.[4] Rosalynn Carter, in her book, Within Our Reach, says, "When a person is under severe stress, the brain has to work very hard to maintain normal blood pressure, heart rate, and temperature, among other things... If a person experiences multiple, continuous stressors, he starts losing the battle. If the stress remains overwhelming or persistent, it will take its toll on a person's health — either physically, mentally, or both."[5] It is important to note that stressors occur in many ways across the spectrum of a person's life, but there is growing awareness of the particular impact of trauma, especially childhood trauma, on all dimensions of whole health.

Not only does stress lead to physical illness, but prolonged stress often precipitates relapse for persons with mental illnesses and addictions. The ability to reduce and/or counter the negative impact of stress is very important for relapse prevention.

How has or does stress impact your mental health, addiction, and overall health and wellness?

3. Lee R. The SuperStress Solution, Random House, 2010.
4. Fricchione GL. The "new" science of mind body medicine. In: Yano E, Kawachi I, Nakao M. (Eds) The Healthy Hospital — Maximizing the satisfaction of patients, health workers, and the community. The Seventh International Teikyo-Harvard Symposium. Tokyo: Shinoharashinsha. 2010.
5. Carter R. Within Our Reach: Ending the Mental Health Crisis, Rodale, Inc., 2010.

The Stress Response

Research has shown that prolonged stress has an adverse effect on one's health.

In order to understand this, it is necessary to understand three things:

1) Metabolism
2) Stressors
3) The Stress Response

Metabolism is the body's chemical process of breaking down organic matter (food) into nutrients and energy that the body can use.

Stressors are events or thoughts that communicate danger to a person's security, threaten the sense of wellbeing, or communicate loss of control.

The **Stress Response,** also known as the "Flight-or-fight Response," is the body preparing to deal with the impending danger or stressor. As a person enters the Stress Response, the body experiences the following to get more energy to the large muscles and vital organs of the body:

- ❍ Metabolism increases
- ❍ Breathing speeds up
- ❍ Heart beats faster
- ❍ Blood pressure increases
- ❍ Blood vessels constrict
- ❍ Stress hormones like cortisol increase

If a person's stressor is a saber-tooth tiger and that person flees to safety or fights to victory, the danger no longer exists. A person has burned most, if not all, of the energy that the body has produced and the body goes into a relaxation mode, which means:

- ❍ Metabolism decreases
- ❍ Breathing slows down
- ❍ Heartbeat slows down
- ❍ Blood pressure decreases
- ❍ Blood vessels open up
- ❍ Stress hormones like cortisol decrease

But what if the stressor is not a saber-tooth tiger? What if the stressor is workplace demands that don't go away?

WHAT HAPPENS THEN?

The body continues to produce extra energy because it thinks energy is needed to survive and expects the energy to burn up.

WHAT HAPPENS TO ALL THE ENERGY THAT IS NOT BURNED OFF BY FLEEING OR FIGHTING?

Much of the energy is held in the stress hormone called cortisol, which deposits fat deep in the abdomen. This type of fat is known as visceral fat, or the non-pinchable "belly fat," which is not attributable to poor diet or lack of exercise, but rather to the effect of stress hormones on the body.[6]

Research shows that visceral fat can be dangerous and is associated with increased risk for heart disease, diabetes, and some forms of cancer, and also affects the function of the liver and weakens the immune system.

IS THERE A WAY TO COUNTER OR STOP THE STRESS RESPONSE WHEN WE ARE NOT ABLE TO FLEE OR FIGHT THE DANGER?

There is, and it is called "The Relaxation Response."

6. Glenville M. Mastering Cortisol — Stop Your Body's Stress Hormone From Making You Fat Around the Middle, Ulysses Press, 2006.

The Relaxation Response

The Relaxation Response is a state of deep rest that changes the physical and emotional responses to stress and decreases heart rate, blood pressure, rate of breathing, and muscle tension. When the Relaxation Response is elicited:

- Metabolism decreases
- Breathing slows down
- Heartbeat slows down
- Blood pressure decreases
- Blood vessels open up
- Stress hormones decrease

If practiced regularly, it can have lasting effects.

The founder of the Benson-Henry Institute (BHI) is Dr. Herbert Benson, a Harvard Medical School trained cardiologist. His work, started in the late 1960s, pioneered mind-body medicine by linking stress to physical health after observing that his patients had elevated blood pressure during regular check-ups. Dr. Benson's research found that by changing thought patterns subjects experienced decreases in their metabolism, rate of breathing and heart rate, and had slower brain waves. These changes appeared to be the opposite of the commonly known "fight-or-flight" or "stress response."[7] Dr. Benson labeled it the "Relaxation Response," which is the foundation of mind-body medicine practiced at BHI.

HOW DOES ONE ELICIT THE RELAXATION RESPONSE?

To elicit the Relaxation Response, there are two essential steps:

- Repetition of a word, sound, phrase, or muscular activity.
- Passive disregard of everyday thoughts that inevitably come to mind and a return to repetition.

7. Benson H. The Relaxation Response, William Morton and Company, 1975.

For Participants to Complete

Stress Management

❍ These are some causes of stress in my life:

❍ These are my favorite activities for relaxing or having fun:

❍ When I am feeling stressed out, I like to do these things to take care of myself:

❍ Here is a list of 3-5 things I might start doing on a regular basis to reduce the impact of stress in my life:

Turn to page 46 and answer questions 1A and 1B

SESSION 3

Improve Your Health

- Healthy Eating
- Physical Activity
- Restful Sleep

Improving Your Health

Usually diet, exercise, and sleep are the first things called to mind when considering health. In the WHAM training, these are referred to as "Healthy Eating," "Physical Activity," and "Restful Sleep."

Healthy Eating

Most people seem to know what foods are healthy — fruits, vegetables, chicken, fish, lean meat, whole grain breads, wild and brown rice, skim or 1% milk, etc. Baked and broiled foods are healthier than fried. People should drink a lot of water and less coffee and soft drinks. Small portions for breakfast, lunch and dinner with a snack in the morning and afternoon are healthier than three larger meals. Stay away from processed foods. While not everyone may follow it, most know what a healthy diet looks like. The federal government has made it easier for Americans to remember — they have released the "MyPlate," which is split into four sections for fruit, vegetables, grains and protein; a smaller circle sits beside the plate for dairy products. You can access the MyPlate at www.ChooseMyPlate.gov.

Physical Activity

It seems like a new book is published every day that touts the merits of a particular exercise program. However, there are many simple ways to increase activity level during the day without having to suit up and go to the gym. For example, walking can be a great, low-impact exercise with numerous health benefits. A person could choose to walk a pet, walk around the block, or through the apartment complex when checking the mail. A person can also get involved in active and fun recreational activities like hiking, bike riding, gardening, dancing, etc. Take a walk while on the cordless phone, take the stairs instead of the elevator, get off the bus a stop early and walk the rest of the way, or park farther away in the parking lot. A pedometer can count steps and help increase the number of steps taken each week. Or go to the local community center gym — it can feel empowering and motivating to join others in a setting that promotes optimum physical health.

Restful Sleep

Restful sleep is another important health issue. While many articles and new reports point to the increased incidence of sleep deprivation, not all people know how to counteract it. It is unhealthy to go without needed sleep. Sleep deprivation significantly affects health. Long term untreated sleep deprivation is associated with many illnesses, including high blood pressure, heart attack, heart failure, stroke, obesity, and mental health problems.

What role has healthy eating, physical activity, and restful sleep played in your mental health, addiction, and overall health and wellness?

Three reasons why I may want to improve my health:

1)

2)

3)

My number one reason is:

For Participants to Complete

Healthy Eating

❍ These are some foods or snacks that I tend to eat or drink on a regular basis:

❍ I think these are some healthy foods:

❍ I think these are some unhealthy foods:

❍ These are some of the healthy foods that I like:

❍ Here is a list of 3-5 things I might start doing on a regular basis to improve my healthy eating habits:

Turn to page 46 and answer questions 2A and 2B

For Participants to Complete

Physical Activity

❍ The following are, or have been, some of my favorite physical activities:

❍ I currently enjoy the following physical activities with other people:

❍ I currently enjoy doing the following physical activities by myself:

❍ Here is a list of 3-5 things I might start doing on a regular basis to include more physical activities in my life:

Turn to page 46 and answer questions 3A and 3B

For Participants to Complete

Restful Sleep

- ❍ I usually get _____ hours of sleep each night.
- ❍ I usually wake up about _____ times during the night.
- ❍ I think I need _____ hours of sleep to function well.
- ❍ I would rate the quality of my sleep on a scale of 1-5 as … (circle the appropriate number.)

  Restless 1 2 3 4 5 Restful

- ❍ I know that I am not getting enough sleep when these things happen:

- ❍ I have learned that I sleep better when I do these things before I go to bed:

- ❍ I have learned that I usually do not sleep well if I do these things before I go to bed, or if these things happen before I go to bed:

- ❍ Here is a list of 3-5 things I might start doing on a regular basis to get more restful sleep:

Turn to page 46 and answer questions 4A and 4B

SESSION 4

The Power of Human Connections

- Service to Others
- Support Network

The Power of Human Connections

"Service to Others" and "Support Network" both have to do with human connections. Dr. Gregory Fricchione, director of the Benson-Henry Institute for Mind-Body Medicine at Massachusetts General Hospital, speaks of these two being one — or the flip side of the same coin. He states that humans need connectedness to survive. This connectedness is at the core of why peer support and self-help are so effective, proving essential to recovery from trauma, especially trauma associated with abuse and neglect that can result in fear and isolation.

There is a healing power in knowing you are not alone. Many people talk about this as part of their recovery story.

Dr. Dean Ornish is a cardiologist who places a lot of importance on the healing power of loving relationships. In his best-selling book, Love and Intimacy, he states, "anything that promotes feelings of love and intimacy is healing; anything that promotes isolation, separation, loneliness, loss, hostility, anger, cynicism, depression, alienation, and related feelings often leads to suffering, disease, and premature death from all causes. When you feel loved, nurtured, cared for, supported and intimate you are much more likely to be happier and healthier. You have a much lower risk of getting sick and, if you do, a much greater chance of surviving." [8]

In his book, Dr. Ornish references research that shows people with the strongest social ties had dramatically lower rates of disease and premature death than those who felt isolated and alone, and those who lacked regular participation in organized social groups had a fourfold increased risk of dying six months after open heart surgery.

Living in isolation not only increases wear and tear at the cellular level, but is also a highway to super stress. Everyone needs a supportive person or two with whom to share good times and bad. Being able to vent, cry, or just have someone listen is often enough to help put a very stressful situation into perspective. In fact, most scientific studies cite social support as the number one determinant of how people handle a stressful situation. In any surgical waiting room, there are usually several supportive "waiters" for every patient being operated on. Belonging to a community — whether it's a knitting circle, a sports league, cat fancier's club, or a monthly dinner group with friends — is an important strategy to handle stress.

Support groups and service to others play a major role in initiating and sustaining recovery in the lives of people with mental illness and addiction.

How has service to others and having a support network helped you relative to your mental health, addiction, and overall health and wellness?

8. Ornish D. Love and Survival, Harper Perennial, 1999.

For Participants to Complete

Service to Others

❍ These are some of the things that I have done or I am currently doing that I would define as "service to others":

❍ Helping others has the following effect on me:

❍ The following are some possible places to volunteer in my community:

❍ Here is a list of 3-5 things I might start doing on a regular basis to provide more service to others:

Turn to page 46 and answer questions 5A and 5B

For Participants to Complete

Support Network

❍ I can trust the following people to be there for me:

❍ These are friends that I enjoy doing things with:

❍ Some people in my support network are:

❍ I attend a support group on a regular basis and find that it benefits me in these ways:

❍ Here is a list of 3-5 things I might start doing on a regular basis to strengthen my support network:

Turn to page 47 and answer questions 6A and 6B

SESSION 5

Maintaining a Positive Attitude

- Optimism Based on Positive Expectations
- Cognitive Skills to Avoid Negative Thinking

Maintaining a Positive Attitude

"Optimism Based on Positive Expectations" and "Cognitive Skills to Avoid Negative Thinking" both have to do with one's attitude. The first has to do with attitude toward the future and the second with attitude toward oneself.

Essential to the strength-based recovery movement for mental illness and addiction is a sense of personal hope that one's life can be better and growing awareness that peer support can foster hope. Hope supports maintaining a positive attitude, and emerging research demonstrates its impact on whole health and resiliency. In a Duke University study of 2,800 heart patients, those with optimistic expectations about their recovery were found 30% less likely to die over the next 15 years than patients with less optimistic expectations, regardless of the severity of their heart disease.[9]

Charles Swindoll, in his article on attitude, states, "The longer I live, the more I realize the impact of attitude on life. Attitude, to me, is more important than facts. It is more important than the past, than education, than money, than circumstances, than failures, than successes, than what other people say or do. It is more important than appearances, giftedness, or skills. It will make or break a company… a church… a home… I am convinced that life is 10% what happens to me and 90% how I react to it."

You've probably heard quotes such as, "Attitude is everything," "Your attitude determines your altitude," or Henry Ford's famous one, "Whether you think you can or can't, you are probably right." These sentiments refer to the human ability to be consciously hopeful or optimistic about the future to avoid or shift away from negative thinking about oneself and one's situation.

Health consultant and writer Martha Beck states, "Your situation may endanger your life and limbs, but only your thoughts can endanger your happiness."[10]

Happiness involves having gratitude for the past, enjoying the present, and being optimistic about the future. Telling a miserable story about one's situation creates suffering. Telling oneself a more positive and grateful story increases happiness.

How does your attitude about the future and your attitude about yourself affect your life relative to your mental health, addiction, and overall health and wellness?

9. Barefoot J et al. Recovery Expectations and Long-term Prognosis of Patients With Coronary Heart Disease, Archives of Internal Medicine, May 28, 2011
10. Beck M. Finding Your Own North Star, Three Rivers Press, 2001

For Participants to Complete

Optimism Based on Positive Expectations

❍ I would rate how optimistic I usually am about the future as:

Not optimistic at all 1 2 3 4 5 Very optimistic

❍ I do these things to help me stay positive:

❍ When I am becoming pessimistic or negative about the future, doing these things helps me become more optimistic:

❍ Here is a list of 3-5 things I might start doing on a regular basis to develop a more optimistic attitude:

Turn to page 47 and answer questions 7A and 7B

Cognitive Skills to Avoid Negative Thinking

Negative self-talk is a problem for many people, this session teaches a skill to combat it.

CAROL'S STORY

Carol awoke and realized she had overslept. "Oh no! I am going be late for work! I said I wanted to get up every morning and go for a walk. I should have known that I wasn't serious. I always have great plans, but I never follow through. When am I going to grow up and start taking some responsibility for my life? I am such a failure!"

As Carol went to the kitchen, she caught a glimpse of herself in the hall mirror. "I shouldn't wear this skirt. It is too tight. If I bend over, I will burst the seams. I have really put on a lot of weight lately. I am so fat and ugly."

As Carol was opening the door of the refrigerator, she said to herself, "What am I doing? I shouldn't eat breakfast. I really need to skip a few meals; then my clothes may fit a little better. I probably need to not eat for a week! No, I've changed my mind. Why don't I eat everything in the fridge? I am a great example of a person who doesn't care how fat and ugly she gets. I am really hopeless."

Carol left the house almost in tears. She got on the bus for work. When she sat in her seat she looked at her reflection in the window. She realized that she had forgotten to comb her hair. "My hair looks horrible. I am so ugly. I ought to shave my head and wear a wig. Nobody could ever like a person who looks like me!"

When Carol got to work she remembered that she had not finished a report that was due that day. As she sat at her computer and got to work, her boss walked by. Carol said to herself, "He is going to think that I just started working on this report, and it is due today. He won't expect it to be very good. I am sure that he will give it to someone more capable to rewrite. I am probably not going to have this job much longer. He will probably fire me soon. What will I do then? I am a fat, ugly failure that no one could ever like. I wish I was dead!"

Reflection on Carol's Story

Something usually occurs to prompt our negative self-talk. There are four events that "jump-started" Carol's self-talk that turned negative: she overslept; she saw in the mirror that her skirt was tight; she forgot to comb her hair; she had not finished a report that was due that day. Each time her self-talk quickly moved from stating the fact(s) to telling herself a story that was not based on facts. "I over slept, I am such a failure." "My skirt is too tight. I am so fat and ugly." "I forgot to comb my hair. Nobody could ever like a person who looks like me." "I haven't finished the report. I will be fired soon."

In each paragraph, when does her self-talk shift from fact to story?

Catch it! Check it! Change it!

Everyone has negative thoughts and engages in negative self-talk. That is not the problem. The problem is when it spirals downward and people end up defining themselves in absolute and permanent negative language.

These three steps help alter attitudes:

1) Catch it early on. This involves knowing when thoughts are moving from fact to story.
2) Check it over against what is actually going on — stick with the facts.
3) Change it to more appropriately reflect reality.

❍ Where could Carol have caught her self-talk moving from fact to story?

❍ How could she have checked her self-talk so that it was more based on facts?

❍ What could she have changed in regard to her self-talk so that it more appropriately reflected the reality of her situation?

❍ If she had done this, how might her day have been different?

For Participants to Complete

List 3-4 actions you have found helpful in catching, checking, and changing your negative self-talk:

1.

2.

3.

4.

In mental illness and addiction, changing one's thoughts is considered crucial to successful strength-based recovery and is the basis for one of the most used evidence-based therapies — Cognitive Behavioral Therapy.

For Participants to Complete

Notes from small group discussion:

If I want to develop my cognitive skills to avoid negative thinking, here are some of things I could start doing on a regular basis:

Turn to page 47 and answer questions 8A and 8B

SESSION 6

Connecting with More Than Self

- Spiritual Beliefs and Practices
- Sense of Meaning and Purpose

Connecting With that Which Is More than Self

"Spiritual Beliefs and Practices" and "A Sense of Meaning and Purpose" seem to involve being connected with something that is more than "me." Spirituality is often defined as a sense of connection that transcends individual experiences and unites the parts into a greater whole. For many people, spirituality, meaning, and purpose cannot be separated. For them, spirituality is the road to meaning and purpose.

Spirituality may include belief in a power that created and controls all of life. It may include a belief in the interrelatedness of all living creatures. It may be a feeling of unity or connection with nature.

For some, spirituality and spiritual beliefs may be very clear and concrete and spiritual practices may center around specific religious rites, rituals, and ceremonies. For others, spirituality and spiritual beliefs may be more vague and mysterious and held in experiences like the following — "At that moment I realized that I was not alone. My pain was the same pain that everyone else in the room had experienced. My shame was their shame. Their shame was my shame. My anger was their anger. Their anger was my anger. I was not alone. And whatever had seen me through all of this had seen them through, also. Whatever had sustained me had sustained them."

Spirituality plays a major role in Alcoholics Anonymous 12-step program as seen in Step 11 — "Sought through prayer and meditation to improve our conscious contact with God as we understood him/her, praying only for knowledge of his/her will for us and the power to carry that out"— and Step 12 — "Having had a spiritual awakening as the result of these steps…"

However, in this manual, spiritual beliefs and practices are defined as a sense of meaning and purpose that can play a crucial role in one's ability to weather life's storms.

How have spiritual beliefs and practices and a sense of meaning and purpose played a role in your life relative to your mental health, addiction, and overall health and wellness? How have they helped you weather the storms of life?

For Participants to Complete

Spiritual Beliefs and Practices

❍ I would rate, on a scale of 1-5, the importance of spiritual or religious beliefs in my life as…

Not important at all 1 2 3 4 5 Very important

❍ These are spiritual or religious beliefs that help see me through the dark and difficult times:

❍ I find these spiritual or religious practices to be very important and sustaining in my life:

❍ Here is a list of 3-5 things I might start doing a regular basis to strengthen my spiritual or religious beliefs and practices:

Turn to page 47 and answer questions 9A and 9B

For Participants to Complete

A Sense of Meaning and Purpose

❍ I would rate, on a scale of 1-5, the amount of meaning and purpose I have in my life as:

Very little 1 2 3 4 5 A great deal

❍ These relationships give my life meaning and purpose:

❍ These activities give my life meaning and purpose:

❍ These experiences give my life meaning and purpose:

❍ Here is a list of 3-5 things I might start doing on a regular basis to create more meaning and purpose in my life:

Turn to page 47 and answer questions 10A and 10B

SESSION 7

Health Risk, Screening, and Shared Decision-Making

- Health Risk
- Health Screening
- Shared Decision Making
- Health Screening Resources

Health Risk, Screening, and Shared Decision-Making

For better whole health self-management, this session focuses on health risk, screening, and shared decision-making.

People living with mental illnesses and addictions are at greater risk than the general population for dying early or experiencing life-altering conditions such as cardiovascular disease, diabetes, hepatitis, or Acquired Immune Deficiency Syndrome (AIDS).

The Medical Directors Council of the National Association of State Mental Health Program Directors released a report in October 2006 that states "People with serious mental illness served by the public mental health system die, on average, 25 years earlier than the general population." The report, Morbidity and Mortality in People with Serious Mental Illness, says that increased morbidity (illness) and mortality (death) are largely due to preventable conditions such as metabolic disorders, cardiovascular disease, and diabetes. Preventable health risk factors include: obesity, smoking, substance abuse, and inadequate access to medical care. The report also states that some psychiatric medications contribute to the risk.

For Participants to Complete

1) Why is it important to self check or seek health screenings to monitor health risk factors?

2) What self-management strategies or health risk screenings are important to prevent untimely death?

3) When was the last time you completed a health risk screening? What tests were done?

Health Risk Screening

To better understand Health Risk Screenings let's first define a medical term know as Metabolic Syndrome. The National Cholesterol Education Program Adult Treatment Panel defines Metabolic Syndrome as the presence of three or more of the following health risk indicators:

- High blood pressure
- Abnormally low "good" cholesterol (HDL)
- Elevated triglycerides (fatty acid)
- High blood sugar
- Abdominal visceral fat (waist circumference)

Each of the indicators above adds some risk for disease. The more the indicators experienced by an individual, the higher the risk for developing type II diabetes and cardiovascular disease. The following are the screenings for the risk indicators above:

- **High blood pressure (hypertension)** is the measurement of the increased blood pressure against the walls of the blood vessels as blood flows through the body. Resistance to the blood flow that increases blood pressure could result from rigid vessels, narrowed vessels, vessels blocked with fatty plaque (cholesterol), or other serious cardiovascular problems. If blood pressure remains high, it can lead to heart attack, stroke (brain attack), kidney failure, heart failure, or blindness. You can have high blood pressure and not know it, which is why it is important to track your blood pressure. A simple blood pressure measuring device is a cuff that inflates with a pressure gauge. Blood pressure is given in two numbers. The top number is your systolic pressure, which is the force of blood on your blood vessels when your heart beats, and the bottom number is your diastolic pressure, which is the force of blood as your heart relaxes between beats.

CATEGORIES FOR BLOOD PRESSURE LEVELS IN ADULTS (measured in millimeters of mercury)

Category	Systolic (top number)	Diastolic (bottom number)
Normal	Less than 120	Less than 80
Pre-hypertension	120–139	80–89
High blood pressure		
Stage 1	140–159	90–99
Stage 2	160 or higher	100 or higher

For Participants to Complete

My blood pressure is: Systolic _____ Diastolic _____

If your blood pressure is high it's a good idea to talk to your doctor. High blood pressure can often be self-managed with healthy eating, physical activity, weight loss, reducing salt, and taking medication.

- **Cholesterols** are fatty chemicals that help with cellular, hormone, and other body processes. When cholesterols are increased beyond normal ranges, they initiate and support diseases such as heart disease, diabetes, and stroke. High-density lipoprotein (HDL) or "good" cholesterol removes excessive low-density lipoprotein (LDL) or "bad" cholesterol from the blood steam. If the HDL is low, then there is not enough to carry away the excess of fatty deposits in the blood vessels. This can restrict blood flow. Screening for the entire cholesterol profile can be done in the doctor's office, clinic, or lab. A blood drop can be examined quickly by a medical professional on a machine with results available in 5 minutes. One advantage to this sort of screening is that results are available immediately. The usual procedure is to take a blood sample from your arm — usually after fasting overnight — after which the sample is sent to a lab for analysis. A follow-up appointment with a medical professional is usually made for interpretation of the lab analysis, or the results may be provided by phone or mail. Screening for cholesterol is done as a lipid (fat) profile, which checks total cholesterol, high and low cholesterol, triglycerides, and a HDL risk factor. Desirable ranges are:
  - Total cholesterol = below 200 mg/dl
  - Triglycerides = below 150 mg/dl
  - HDL (good) = above 60
  - LDL (bad) = 100 mg/dl or below
  - HDL risk factor = average risk factor is 3.4
- **High Blood Glucose** is also another important risk factor people can self monitor to prevent or manage diabetes. Blood glucose is the amount of sugar in the blood at the time of testing. Normal range is 80-100 mg. Screening can be done by a finger-stick blood drop measured by a glucometer. To diagnose or man-

A1c TEST STANDARDS

- Normal range for the A1c test is between 4% and 6%
- Over 6% means that a person has poor blood sugar regulation
- The goal for a person with diabetes is to be below 7%
- The higher the A1c level, the greater the risk of developing complications of diabetes

11. American Diabetes Association: "A1C Test." Droumaguet, C. Diabetes Care, 2006; 29:1619. Steffes, M. Clin Chem, 2005; 51:1569. Selvin, E. Diabetes Care, 2006; 29:877.

age diabetes, a medical professional orders a lab test called a **Glucose Tolerance Test**, which is usually administered in a doctor's office, clinic, or hospital after 8 hours of fasting. Another blood test used to manage diabetes is called **Hemoglobin A1c Test,** which determines how well diabetes is being managed over a 3-month period. This test can also be done in a doctor's office or clinic with a blood-stick blood drop, which can be analyzed in 5 minutes by a machine, or by having blood drawn from your arm that is then sent to a lab for analysis. See the A1c Test Standards provided in the shaded box on the previous page.

OTHER HEALTH RISK SCREENINGS

- **HIV Test** for human immune deficiency virus is a blood screening for the precursor of AIDS. HIV weakens the body's natural defense system against illness. AIDS is the last stage of HIV infection. Blood can be drawn at the doctor's office or clinic, or at the Public Health Department. The blood is then sent to a lab for analysis, after which a medical professional will discuss with an individual the results and any necessary follow-up. The blood tests will be either positive or negative. HIV positive can be treated and managed successfully without ever manifesting AIDS. This virus can be given to another individual through blood contamination from unprotected sex, sharing needles, and other contact with blood.

- **Hepatitis C Test** is a blood screening for a disease of the liver. The blood is usually drawn from the arm at a doctor's office or clinic, or at the Public Health Department. The blood is sent to a lab for analysis, after which a medical professional will discuss the results and any necessary follow-up. The blood tests will be either positive or negative. Hepatitis can be treated and managed successfully.

Health Discussion

1) What challenges do you think people may face when screening themselves for health issues?

2) What are some ways that you can be supportive of the people you work with if someone becomes upset about this information?

3) What tools can you use?

ROLE PLAYING SHARED DECISION MAKING — PREPARING FOR YOUR DOCTOR'S MEETING AND HEALTH TESTS

An important emerging concept in whole health self-management is "shared decision making." In the WHAM training, shared decision making is defined as "the collaboration of a medical professional and recipient of whole health services to determine the treatment and self-management actions for maximizing whole health." In this collaboration, both the medical professional and recipient of whole health services should be valued as experts. The doctor may be an expert on medications, tests, and treatment, but equally important is the recipient of whole health services who uses skills like person-centered planning and the eliciting of the Relaxation Response as an expert on self-management.

A good way to teach skills for shared decision making is through role playing, which can be introduced during this part of the training.

Health Screening Resources

Primary Care Visits – Most people receive health screenings from their primary care doctor during annual physicals. Of course, many people with ongoing health conditions see their doctor more frequently, and the doctor may not set aside a specific visit for an "annual physical."

During these meetings, a person should get his or her height, weight, waist circumference, blood pressure, blood glucose, cholesterol, and triglycerides tested. Many tests are done via blood work, and some people may need to go to a lab in order to get blood taken.

Health Fairs – Many hospitals, health communities, schools, and other public health efforts offer health screenings in the community. These events often offer limited screening areas and do not typically offer blood tests. Typical screenings related to Metabolic Syndrome include height, weight, waist circumference, and blood pressure. Some other kinds of screenings may also be included. While these events may not offer all areas of Metabolic Syndrome testing, they can be a source of information. Many health fairs also offer a variety of health products that can be motivational, such as pedometers and stress balls.

Mental Health and Addiction Services can play a role in getting people access to health screening in a variety of ways.

- Psychiatrists and other clinicians are increasingly paying attention to weight gain and other physical health factors in their practices.
- Mental health and addiction centers may have nursing staff who can take a blood pressure reading or help with other health screenings.
- Peer support/self-help groups and facilities can provide health screening access in various ways, such as bringing a nurse in to do screenings, getting members to a health fair, etc.
- Self-testing is done by the individual at home. Many of the health products needed to test one's health are becoming more readily available to consumers. These products can often be found at a local health food store or drug store. Scales, measuring tapes, blood pressure machines, and blood glucose monitors can all be purchased at reasonable prices (health insurance may reimburse or discount these items).

Other things to consider in helping peers self-monitor their own health and risk factors or engaging them in health risk screenings:

- Actions a person can take if findings are outside normal limits, including basic common lifestyle changes (e.g., increase physical activity, dietary changes, or reduction in simple carbohydrate consumption to lower triglycerides, etc.)

- ❍ Ways to help people deal emotionally with abnormal findings (need for professional retest, treatability of conditions, etc.)
- ❍ Importance of confidentiality of personal health information
- ❍ Proper use of personal health records
- ❍ Safety aspects of finger sticks (e.g., including use of sterile lancets, avoidance of contact with body fluids, and the importance of minimum necessary lancing depth)
- ❍ A sense of "abnormal" test results versus "critical abnormalities" (e.g., systolic BP >200 or FBG >400)

OTHER RESOURCES:

- ❍ Mayo Clinic — www.mayoclinic.com — Online health screening guidelines sheet that is interactive and fun to use.
- ❍ Medline Plus — www.nlm.nih.gov — Health screening tests information page.
- ❍ National Council for Community Behavioral Healthcare — January 2011 — Staying Well: It's as simple as your ABCs and D&E

SESSION 8

Key to Success 1

- Review and Prioritization
- Setting a Person-Centered Goal
- Applying the IMPACT Criteria

Setting and Clarifying Your Whole Health Goal

For Participants to Complete

HEALTH STRENGTHS: (Put a check mark by those that you think are your strengths)

	General Health
	My blood pressure is within the normal range.
	My blood sugar level is within the normal range.
	My cholesterol level is within the normal range.
	My body weight is within the normal range.
	I have a physical examination on a regular basis.
	I have a primary care doctor that I trust and can work with.
	I do not have a chronic illness.
	I have a chronic illness, but I have learned how to control it.
	I know what areas of my health I want to improve.
	Health and Resiliency Lifestyle
	I know what causes stress in my life.
	I know some things I could do to make my life less stressful.
	I know what foods are healthy and unhealthy.
	I know some healthy foods that I like and could add to my diet.
	I understand the value of physical exercise.
	I know some physical activities that I enjoy and could add to my life.
	I regularly get an adequate amount of sleep.
	I know some things I could do to improve the quality of my sleep.
	I know that when I help others I feel better about myself.

	I know some things I could do to help others and that I would enjoy doing.
	I have people in my life who I enjoy being around.
	I know some things that I could do to increase my support network.
	I think of myself as an optimistic person in relation to the future.
	I know some things I could do to become more optimistic about the future.
	I have some cognitive skills to help avoid negative thinking.
	I know some things that I can do to improve my cognitive skills to avoid negative thinking.
	I have spiritual beliefs and practices that sustain me during difficult times.
	I know some things that I can do to strengthen my spiritual life.
	I have a strong sense of meaning and purpose in my life.
	I know some things that I can do to increase my sense of meaning and purpose.
	I know some things I could do to improve my health and resiliency.
	I am ready to work on improving my health and resiliency.

I think my current lifestyle is healthy and resilient in the following ways:

I could use these strengths to improve my health and resiliency:

Review and Prioritization

For Participants to Complete

1A If I decide it is important to **reduce stress** in my life or practice more stress management skills to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

1B *The benefit of doing this would be:*

2A If I decide it is important to create **healthier eating** habits in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

2B *The benefit of doing this would be:*

3A If I decide it is important to engage in more **physical activity** in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

3B *The benefit of doing this would be:*

4A If I decide it is important to get more **restful sleep** in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

4B *The benefit of doing this would be:*

5A If I decide it is important to get more involved in **service to others** in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

5B *The benefit of doing this would be:*

6A If I decide it is important to expand and strengthen my **support network** in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

6B *The benefit of doing this would be:*

7A If I decide it is important to develop a more **optimistic attitude** about the future in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

7B *The benefit of doing this would be:*

8A If I decide it is important to strengthen my **cognitive skills to avoid negative thinking** in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

8B *The benefit of doing this would be:*

9A If I decide it is important to strengthen my **spiritual beliefs and practices** in order to increase my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

9B *The benefit of doing this would be:*

10A If I decide it is important to have more **meaning and purpose** in my life in order to improve my health and resiliency, I could do the following to accomplish that:
(Make sure it is something you are currently not doing, can do, and think you might enjoy)

10B *The benefit of doing this would be:*

Stating My Whole Health Goal

For Participants to Complete

❍ Looking over what I could do in each of the 10 health and resiliency factors and the benefits of doing each, I believe that improving these three factors would have the greatest positive impact on my life:

1)

2)

3)

❍ These three factors are important because I want to improve the following area(s) of my life:

❍ I want to improve these areas of my life because:

❍ I think I might be ready to improve these areas because:

❍ Taking all of this into consideration and using the following formula, my whole health and resiliency goal is:

In order to (explain why I want to achieve the goal) .....

.....

.....

.....

My whole health and resiliency goal is (explain what I want to achieve or what I want to be able to do).....

.....

By (recommend 8-week time period to coincide with WHAM group meetings).....

.....

APPLYING THE IMPACT CRITERIA

A goal is something we want and that we are willing to work for because we want the benefits. It is the potential benefits that motivate us. Therefore, the more you can get the goal statement to incorporate the potential benefits, the more impact the statement will have on the person's motivation and ability to accomplish the goal.

Often the initial goal is stated in a way that the support person will not know it has been accomplished without being told that it has. Example – "I want to feel better." Or it may be stated negatively as something a person wants to stop doing, avoid, or eliminate from their life. Example – "I want to quit smoking." Or it may be stated as something a person wants immediately rather than something that requires numerous actions to accomplish. Example — "I want to exercise five days a week."

If the initial goal statement does not meet the IMPACT criteria, it is helpful to relate it to the benefits by asking the following questions — Why do you want this? What will the benefits be? How will your life be different if you accomplish this goal? If you accomplish this goal, what will you be able to do that you can't, or aren't, doing now? When these questions are asked, the new goal statement gets related to the benefits and leads to actions that the person can take to accomplish the goal.

IMPACT Criteria Questions About Goals

- **I:** Does it Improve the quality of my health and resiliency?
- **M:** Is it Measurable in terms of my supporter knowing if I have accomplished it?
- **P:** Is it Positively stated as something new I want in my life?
- **A:** Is it Achievable for me in my present situation and with my current abilities?
- **C:** Does it Call forth actions that I can take on a regular basis to begin to create healthy habits?
- **T:** Is it Time limited in terms of when I will begin and when I plan to accomplish it?

For Participants to Complete

RE-STATE YOUR GOAL USING THE FORMULA BELOW SO IT MEETS THE IMPACT CRITERIA:

In order to (explain why I want to achieve the goal) .....

.....

.....

.....

My whole health and resiliency goal is (explain what I want to achieve or what I want to be able to do).....

.....

.....

.....

By (recommend 8-week time period to coincide with WHAM group meetings).....

.....

.....

.....

SESSION 9

Keys to Success 2 & 3

- Weekly Action Plan
- Daily/Weekly Personal Log

Weekly Action Planning and Personal Log

Learning to create a **weekly action plan** that helps a person reach his or her whole health goal is crucial to success. The actions must be healthy and such that a person can engage in them multiple times a week.

ACTION PLANS FOR GOALS THAT REQUIRE DEVELOPING A NEW BEHAVIOR, HABIT, OR LIFESTYLE

While the actions in the weekly action plan may vary from week to week, the actions need to relate to the set goal and consist of healthy behaviors that create a new discipline in one's lifestyle. Remember, the action plan needs to be something that the person wants to do and can expect to do during the next week. The action plan needs to focus on what a person is creating that is new and is helping him or her move in the desired direction, not changing or eliminating what is "wrong." Don't focus on bad habits. That gives these habits power. Remember, whatever you focus your energies on, you give power to; therefore, focus on what you want to create, not on what you want to change. The action plan needs to focus on creating good habits, not getting rid of bad ones. If a person wants to create an action plan for eliminating certain things in his or her life, that is OK, but it is best to stay focused on the positive, what the person wants, and the person's strengths. Also, it is helpful if the plan contains actions that the person is able to take multiple times during the week, in order to establish a new discipline in his or her life.

For Participants to Complete

Some of the things I could possibly do, or need to do, each week to accomplish my goal are:

1)

2)

3)

4)

5)

Using the whole health goal that you just created, you will now practice creating a weekly action plan.

This action plan needs to answer the following questions:

1. What will you do?
2. How much will you do?
3. How often will you do it?
4. When will you do it?

EXAMPLES

Stress Management:

1) What will you do?
   I will practice the Relaxation Response
2) How much will you do? **10 minutes**
3) How often will you do it? **Four days this week**
4) When will you do it? **Before I go to work**

Healthy Eating:

1) What will you do? **I will eat fruits and vegetables**
2) How much will you do?
   Three servings of fruits and/or vegetables
3) How often will you do it?
   Three different days this week
4) When will you do it? **At lunch and/or dinner**

Physical Activity:

1) What will you do? **I will walk**
2) How much will you do? **One-half mile**
3) How often will you do it? **Three times this week**
4) When will you do it? **After work and before dinner**

Restful Sleep:

1) What will you do?
   Turn off the TV and take a warm bath
2) How much will you do? **For 20 minutes**
3) How often will you do it? **Three times this week**
4) When will you do it? **At 10:00 PM**

Service to Others:

1) What will you do? **Volunteer tutoring**
2) How much will you do? **One Hour**
3) How often will you do it? **Twice this week**
4) When will you do it? **After school**

Support Network:

1) What will you do? **Attend a support group**
2) How much will you do? **For one hour**
3) How often will you do it? **Once a week**
4) When will you do it? **In the evening**

Optimism Based on Positive Expectations:

1) What will you do? **Positive affirmations**
2) How much will you do? **One affirmation repeated three times**
3) How often will you do it? **Three days a week**
4) When will you do it? **Early in the morning before I begin the day**

Cognitive Skills to Avoid Negative Thinking:

1) What will you do? **Note my negative words**
2) How much will you do? **As much as possible**
3) How often will you do it? **As often as possible**
4) When will you do it? **When I catch myself**

Spiritual Beliefs and Practices:

1) What will you do? **Morning devotion**
2) How much will you do? **15 minutes**
3) How often will you do it? **Three days**
4) When will you do it? **Early morning**

A Sense of Meaning and Purpose:

1) What will you do? **Read an autobiography**
2) How much will you do? **30 minutes**
3) How often will you do it? **Four days**
4) When will you do it? **Before going to bed**

SAMPLE ACTION PLAN

- ❍ Week .....
- ❍ What? .....
- ❍ How much? .....
- ❍ How often? .....
- ❍ When? .....
- ❍ Confidence level? .....

Once you've created an action plan, the question arises as to whether you will implement it. The Confidence Scale is used to increase the likelihood of success. Continued success — even in small doses — increases one's self-confidence and the desire to set and accomplish more goals. It works like this: you decide how confident you are about the weekly action plan, using a scale of 0-10 (0 = no confidence and 10 = total confidence). **The Confidence Scale** score should be 7 or higher. You can increase the number by lessening the actions (the "how many" and the "how much"), by identifying and removing barriers, and/or by increasing the support. For example, you may initially plan to walk 1 mile a day on 5 days during the next week, but you've selected a score of only 5 on the Confidence Scale. To increase the Confidence Scale score to 7 or above, you could choose to reduce the planned walking distance and/or the number of days you will walk. Or you can choose to ask for certain supports such as asking someone to phone you with a reminder, or to walk with you.

A daily/weekly personal log is simply a way of keeping a record of what you actually do each week in relation to your weekly action plan. It is important early on that the peer leader, the peer, and the peer support group work out a simple and doable way of keeping a daily/weekly log to be reported each week at the support group. For your convenience there is a space provided in the Weekly Action Plan Pocket Guide to log your daily/weekly progress.

SESSION 10

Keys to Success 4 & 5

- One-to-One Peer Support
- Peer Support Group

One-to-One Peer Support and the Weekly Peer Support Group

Supporting peers outside of the support group is very important. Ideally, this is contact that occurs between the weekly support group meetings. There are two ways this can be done. The first involves the peer leader who is leading the support group to contact each participant between meetings. The second occurs during the support group meeting when each peer selects a peer to be the support person for the next week and make contact between meetings. The first procedure is recommended for the first few weeks of the group meetings.

However the peer support is structured, the peer supporter makes arrangements to contact his or her peer 2-4 days after the support group meets. This can be in person or by phone. The peer supporter asks how the other person is doing in relation to the action plan and log. If the other person is doing OK, the peer supporter expresses appreciation and encouragement to attend the next support group meeting. If the other person is not doing well, the peer supporter asks how to help.

The weekly peer support group is foundational to the success of the WHAM process. Here are suggested guidelines for conducting a group:

1) All group participants should be working on a health goal and have agreed to use the 5 Keys to Success.

2) The group can be facilitated by any one of its members. If it is facilitated by a peer leader, the peer leader must meet the criteria of guideline #1 above.

3) During the first group meeting a "comfort contract" that group members agree on should be created to serve as the group's rules of conduct. (Please note: a sample comfort contract is provided as a training handout.)

4) The meeting follows this format:

    a. The leader welcomes everyone, opens with a short Relaxation Response exercise, and leads the discussion for that week.

    b. The leader shares his or her weekly action plan and the associated activities from the past week using the personal log as a reference.

        - If the action plan was accomplished, the group celebrates the accomplishment(s) and moves to the next person.

        - If the action plan was not accomplished, a group member asks what the barriers were and what could be done next week to help succeed, and if the person wants suggestions from group members who have struggled with the same situation.

- After brainstorming suggestions, recommend that the person choose what may be helpful to be used next week.

c. Move to the next person and repeat the above process.

d. After everyone has had a chance to share, the focus shifts to the next week. Starting again with the leader, each person shares his or her action plan for the next week.

   - Using the Confidence Scale each person states his or her confidence in relation to accomplishing the actions. If a person's Confidence Scale ranking is seven or above, move to the next person. If it is less than seven, the group works with the person to get the Confidence Scale ranking to a score of seven or higher.

   - Decide who will be the support peer for that person for the next week.

e. After everyone has had a chance to participate, check to see if someone would like to share anything else in closing. Remember that this is a whole health support group and that should be the focus. Other issues and concerns can be dealt with after the group meeting is over.

GLOSSARY

Abdomen: The part of the body between the chest and pelvis.

Abnormal: Test results or system functioning outside the range of what is typically expected.

Abnormally high glucose: Blood sugar levels at higher-than-recommended ranges, which do not meet the diagnostic criteria for diabetes. Often called pre-diabetes, implying that they represent a trend which, if not stopped, will lead to diabetes.

Adrenaline (or epinephrine): A hormone (a chemical in the body) secreted by the adrenal gland. It is part of the "fight-or-flight" response.

Ancestors: Parents, grandparents, etc.

Behavioral health services: Services that help to treat mental illnesses and addiction disorders.

Blood pressure: How hard blood pushes against the walls of blood vessels as the blood flows through the body.

Blood sugar level: The amount (or fraction) of a person's blood circulating in his/her veins and arteries that is glucose, the form of sugar carried in the human bloodstream. It is normally expressed in milligrams/deciliter (mg/dL).

Blood glucose: The simple sugar carried in the human bloodstream.

Billable service: Any service provided that can be billed to the party paying for it, whether the person, his or her insurer, or a government program.

Brain waves: A measurable electrical activity of the brain.

Carbohydrate consumption/reduction: Carbohydrates (CHOs) are those foods rich in either complex carbohydrates (starches) or simple carbohydrates (sugars). High CHO intake can lead to middle body weight gain and challenges glucose and insulin regulation in the body. Many people may modify their diets to reduce total carbohydrates.

Cardiovascular disease: Any of a variety of illnesses of the heart and its surrounding organs. May include aortic aneurysms, heart failure, heart attack, and electrical disturbances of heart rhythms.

Cellular level: The cell is the basic building block of all animal and plant life. It is the smallest level of matter that can be called "life." Most basic processes in plants and animals — converting food to energy, transferring oxygen to the bloodstream, generating new cells, etc., take place at the cellular level.

Cellular stress: A set of challenges to the continued viability of a cell resulting from oxidation issues.

Cognitive skills: Basic brain skills needed to remember, calculate, make logical connections, and carry out other functions for daily living activities.

Consciously: Thoughts or actions taken with awareness of what they are and their impact or outcome.

Cortisol: A hormone produced by the adrenal gland, released in response to stress.

Depression: A mood in which a person feels significant negativity, or a family of mental health disorders, defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), involving an extended period of depressed mood.

Determinant: Any one factor that has an impact on an outcome.

Diabetes: A condition where the pancreas does not put out a sufficient amount of the hormone insulin, or where other physiologic processes result in the body's inability to produce sufficient insulin or otherwise maintain its blood sugar levels.

Diastolic: The blood pressure measured at the point of lowest compression.

Disease vulnerability: Any process or condition that increases the chance a person may develop a disease, or of a disease having a more harmful or negative course in that person. Factors include overall health, immune health, hygiene factors, and hereditary or genetic factors.

Disorders: Any condition of the body where an organ or process is not operating properly.

Elevated blood fats: The body uses various lipids (kinds of fat molecules) in the bloodstream to carry out needed normal circulation and functioning. Some of these must be kept at or below a certain density (number of molecules per milliliter of blood) to avoid raising the risk of stroke or other heart disease.

Elevated sugar: The blood sugar level in a human who has not eaten for at least 4 hours should be between 85 and 110 mg/dL. Levels above this can be considered elevated (hyperglycemia), and may lead to a diagnosis of diabetes.

Elevated triglycerides: Having a fraction of certain fatty acids in the bloodstream above recommended guidelines (150 mg/dL, measured after fasting at least 8 hours).

Encompassing: Having within its range or scope. For instance, good oral self-care practices could include brushing, flossing, rinsing, watching your diet (especially avoiding sugary foods), and scheduling hygiene appointments with a dentist.

Engaging power: A strength of the coaching approach that includes engaging people to take and maintain positive steps toward their recovery.

"Fight-or-flight" or "Stress Response: Quick responses to situations that threaten safety. Complex chemical and nervous system responses set in to cause people to be able to make a decision — fight or flee — and take action quickly.

Finger sticks (sometimes called a finger prick): A way of collecting a small amount of blood by making a "pinprick" incision in the side of a finger using a lancet, and squeezing the finger as needed.

Genetically susceptible: Genetics is the complex set of characteristics and traits every living creature inherits from ancestors. Some genes actually carry diseases. Others may carry susceptibility, so some combination of that gene and other environmental or behavioral factors will determine whether a person develops the disease.

Hemoglobin A1c test: A blood test that checks if diabetes is under control. It is a blood test that gets sent to the laboratory, or can be done through an over-the-counter self test.

High Density Lipoproteins (HDL): So-called "good" cholesterol in the bloodstream.

Healing power: Any strengths that have the capacity to remedy disease. Strengths may include traditional medical care and medication, complementary and alternative therapies, positive thinking, self-will, human companionship, laughter, and more. Some people with strong faith consider their deity, prayer, or various holy objects to have healing powers.

Health fairs and health screenings: Educational and interactive events that provide basic preventive medicine and medical screening to people in the community.

Heart disease: Any of various health conditions that affect the functioning of the heart and its associated blood vessels.

Hormone: A chemical sent out from a gland or cell in one part of the body that affects other body organs.

Human connections: Relationships with other people — can be romantic, family, friendship, business relationships, or many others.

Inflammation: Part of the operation of the immune system, including white blood cells, that fights infection in the body.

Insulin: A hormone secreted by the pancreas that the body uses to process sugars in the bloodstream.

Integrated primary health services: Integrating service delivery of primary, mental health, and addictions care by coordination, co-location, or in a 'health home.'

Impair digestion: Digestion is the process by which food is taken into the body, processed to extract nutrients, and then the remains are excreted as waste. A series of organs carries out digestion via the alimentary canal. Impaired digestion is a problem with one or more of these organs, which stops a person from digesting their food, or affects what foods they are able to eat.

Kidney failure: The kidneys (human beings have two, but can function with one) are essential organs that filter waste from the bloodstream. Kidney failure is the inability of the kidneys to perform that function.

Life-enhancing: Anything that can help a person improve personal satisfaction and/or wellbeing.

Lifesaving resources: Any assets needed to prevent loss of human life. The collection of hospitals, emergency departments, ambulances, blood banks, etc. may make up a community's lifesaving resources.

Low "good" cholesterol: Having a fraction of HDL in the bloodstream that is below recommended levels.

Medicaid coverage: Medicaid is the United States health program for certain people and families with low incomes and resources. It is jointly funded by the state and federal governments, and is managed by the states. Medicaid pays for healthcare coverage for people with chronic health challenges who do not have other coverage and have limited financial resources. In some states, it also covers people with no chronic health challenges who do not have other coverage and have limited financial resources.
Medicaid plans are the main payer for public mental health services.

Mental function: All of the processes that take place within our minds — the conscious area of our brains. Examples are perception, memory, creativity, imagination, emotion, and belief.

Mercury: A metallic element, liquid at room temperature, which previously was used in thermometers and instruments for measuring pressure, such as barometers and blood pressure devices.

Metabolic syndrome: A collection of health conditions that sometimes occur together, — abdominal obesity, high body mass index, high blood pressure, and diabetes.

Metabolism: The set of chemical reactions that take place in the body to sustain life.

Metastatic breast cancer: Cancer is a health condition involving the uncontrolled growth of cells in one or more parts of the body. Metastatic breast cancer is a cancer that starts in the breast, and spreads (metastasizes) to other parts of the body.

Millimeter: A unit of measure, approximately equal to 1/25 of an inch.

Mind-body resiliency factors for prevention: That set of factors that help an individual ward off disease and illness and the negative aspects of physical and emotional stress.

mmHg: Millimeters of Mercury, a measurement of pressure in a barometer, blood pressure instrument, or similar device. This is still the unit for pressure, even in devices which do not actually use a tube of mercury.

Normal range: The results of a test that are between recommended high and low values.

Negative impact stress response: When the body and brain respond to stressful situations, they take away attention and resources from less critical factors. Difficulty digesting food, or reduced sexual response, may be examples of negative impact stress response.

Negative Thinking /Pessimistic: Thinking based on the expectation that desired outcomes are not going to happen or are more likely not to happen. Negative self-talk is reminding oneself of these negative thoughts/expectations.

Noradrenalin (or norepinephrine): A hormone (a chemical in the body) primarily secreted by the adrenal gland. Noradrenalin also serves as a neurotransmitter (a chemical in the brain used to "talk" between cells). It is part of the "fight or flight" response.

Nonessential organs: Systems of cells in the body that may or may not carry out a function, but that the body can function without if needed. An example is the spleen.

Nurtured: The sense of being cared for in an unconditional fashion, such as most people (and animals) do for their infants.

Nutrients: Substances taken in by the body that are needed for cells to function well and repair themselves.

Normal cell regeneration: The cell is the smallest basic building block of every living organism. Human cells are organized into organs (collections of cells to carry out a specific purpose), and many organs have multiple specialized types of cells. As cells die, there is a physiologic process for new ones to be created or "regenerated."

Optimism based on positive expectations: Thinking based on expectations for good outcomes — the expectation that good things are going to happen or are more likely to happen.

Peer support: All of the ways in which a person gets help from someone who is like them, whether friend, trained peer worker, fellow support group member, or other — as opposed to professional support, where the person helping them is doing so on the basis of a formal credentialing and/or training. Peer support operates from knowing that the individual has shared a similar experience and can be a model for others willing to learn and grow. Peers come together with the intention of changing unhelpful patterns, getting out of difficult places, and building relationships that are respectful.

Person-centered planning: Delivery of medical, mental health, substance abuse, or rehabilitation services on an individualized (versus standardized) basis, with the person's expressed wants, strengths, and needs serving as the basis for how services are delivered.

Perspective: Your way of uniquely viewing people, places, and situations.

Physical activity: Anything a person does to keep moving and exert themselves. Bodily movement produced by skeletal muscles that requires energy expenditure. It includes both intentional exercise (when you exercise for your health), and normal activity as you work, take care of your home and family, etc.

Physical inactivity: Low levels of moving around. Low levels of energy expenditure. Fourth leading risk factor for early death according to the World Health Organization.

Pre-hypertension: Blood pressure in either the systolic or diastolic measurement that is higher than recommended ranges, but not so high that it creates significant risk.

Premature death: A life that ends younger than otherwise might be expected.

Psychosocial treatment: Services or treatments other than medication that can help a person pursue recovery. These could include psychotherapy, employment and other rehabilitation services, peer support services, or specialized services that may be aimed at helping a person live successfully in the community, pursue education, employment or other valued goals, or fulfill valued life roles.

Psychological: Of or related to the mind including thoughts, thought processes, and emotions.

Primary care provider settings: Offices and clinics where people get medical care from a primary care or internal medicine physician, nurse practitioner, or physician assistant.

Psychological stress: The mind's inability to cope with a challenge of some kind. Typical sources are conflict, frustration, pressure, loss, and threat.

Relapse: Any re-occurrence or rise in symptoms. A person can have a relapse of poison ivy due to insufficient cleaning of linens that came in contact with their previous skin outbreak or a relapse of migraine headaches due to a lot of stress. Relapse of symptoms can occur for people living with mental illnesses and addictions.

Restful sleep: Sleep that gives our bodies and brains the chance to relax and rebuild.

Self-testing: Health measurement (e.g., weighing yourself every week), and tests that can be done at home using specialized equipment or chemical setups that otherwise would be done in a healthcare setting/clinical laboratory. Examples include blood glucose monitoring, lipid profiles, home blood pressure monitoring, and many others.

Strength-based: Moving away from seeing a person as a set of problems, deficits, or challenges that need to be 'fixed,' to recognizing talents, skills and supports which he or she uses — with or without professional assistance — to lead a full and satisfying life.

Stroke: Occurs when a clot blocks the blood supply to part of the brain or when a blood vessel in or around the brain bursts. Causes parts of the brain to become damaged or die. Sometimes called a brain attack.

Substance use conditions: Health conditions where a person's life (social relationships, ability to fulfill responsibilities as a worker, family member, etc.) may be negatively impacted by use of drugs, illegal substances, and/or alcohol.

Support network: People a person can rely on for support, companionship, and to help deal with life challenges. Can include "natural supports" such as friends, family, peers, co-workers, and church members, and "paid supports" such as peer specialists, job coaches, personal trainers, therapists, doctors, etc.

Systolic: The blood pressure measured at the point of highest compression.

Type II diabetes mellitus: A disease where the body is not able to create or use enough of the hormone insulin to keep blood glucose at safe levels.

Vent: The opportunity to share feelings and emotions.

Visceral fat: Fat in the body inside the abdominal cavity packed around the stomach intestines, kidneys, and liver.

Vital organs: Collections of cells in the body that carry out a function that is essential and cannot be taken over by another organ.

Weakened immune system: The immune system is a complex set of organs and chemical processes that protect the body from disease, poison, and the after-effects of injury. Various diseases can weaken the immune system and make a person more susceptible to disease.

APPENDIX MATERIALS

1. My Plate
Web site: www.choosemyplate.gov
My Plate is the current nutrition guide published by the U.S. Department of Agriculture, depicting a plate and glass divided into five food groups. It replaced the USDA's MyPyramid guide on June 2, 2011, ending 19 years of USDA food pyramid diagrams.

2. Mental Health America Live Your Life Well
Web site: http://www.liveyourlifewell.org/
The website designed to help you cope better with stress and create more of the life you want.

3. NAMI's Hearts and Mind: A Roadmap to Wellness
Web site: www.nami.org/Content/NavigationMenu/Hearts_and_Minds/ FINALfinalRoadmaptoWellness.pdf [PDF Format - 653 Kb]
An interactive online educational initiative promoting the idea of wellness in mind and body.

4. BMI — Body Mass Index
Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion
Web site: www.cdc.gov/nccdphp/dnpa/bmi/index.htm
Provides a definition for BMI, as well as separate BMI calculators for adults, children, and teens. Additional nutrition, weight, and health resources are also available.

5. Weight-Control Information Network
DHHS, National Institutes of Health (NIH), National Institute for Diabetes and Digestive and Kidney Diseases (NIDDK)
Web site: http://win.niddk.nih.gov/index.htm
Provides the general public, health professionals, the media, and Congress with up-to-date, science-based information on weight control, obesity, physical activity, and related nutritional issues.

6. Americans Consume Too Many Calories from Solid Fat, Alcohol, and Added Sugar, U.S. Department of Agriculture (USDA), Center for Nutrition Policy and Promotion Nutrition Insight 33, June 2006.
Web site: www.cnpp.usda.gov/Publications/NutritionInsights/Insight33.pdf
Describes the amounts of discretionary calories (from all sources of solid fat, alcohol, and added sugar) consumed by Americans.

7. From Wallet to Waistline: The Hidden Costs of Super Sizing
National Alliance for Nutrition and Activity (NANA)
Web site: www.cspinet.org/w2w.pdf
Summarizes the true costs of super sizing portions and focuses on the fact that bigger is not necessarily better. Nutrient analysis tables are also included.

8. Healthy Body Calculator
Ask the Dietitian - Joanne Larsen, MS, RD, LD
Web site: www.dietitian.com/calcbody.php
Calculates body mass index (BMI) and provides information on nutrient composition, body shape, and corresponding disease risk. This web site also provides personalized activity suggestions for weight loss.

9. HealthyDiningFinder.com
Healthy Dining
Web site: www.healthydiningfinder.com
Searches for healthier meals at restaurants ranging from fast food to fine dining. Includes information such as calories, fat, and sodium.

10. How Active Are You? Calorie Calculator
Center for Science in the Public Interest
Web site: www.cspinet.org/nah/09_03/calorie_calc.html
Projects targeted calorie intake determined by a person's gender, age, height, weight, and activity level.

11. Interactive Menu Planner
DHHS, NIH, NHLBI, Obesity Education Initiative
Web site: http://hp2010.nhlbihin.net/menuplanner/menu.cgi
Guides daily food and meal choices based on a person's daily calorie needs.

12. Make Your Calories Count:
Use the Nutrition Facts Label for Healthy Weight Management
Food and Drug Administration (FDA), Center for Food Safety and Applied Nutrition
Web site: http://www.cfsan.fda.gov/~ear/hwm/labelman.html
Interactive learning program that provides users with information to help plan a healthy diet while managing calorie intake.

13. InSHAPE
Web site: www.mfs.org/services/inshape/inshape
InSHAPE is a wellness program for individuals with mental illness. The goal of InSHAPE is to improve physical health and quality of life, reduce the risk of preventable diseases, and enhance the life expectancy of individuals with serious mental illness.

14. ACE STUDY
Web site: www.acestudy.org
The ACE Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. It is perhaps the largest scientific research study of its kind, analyzing the relationship between multiple categories of childhood trauma or adverse childhood experiences (ACEs) and health and behavioral outcomes later in life.

Contact Information for Local Resources:

SAMHSA-HRSA

Center for Integrated Health Solutions

1701 K Street, Suite 400
Washington, DC 20006

Email: Integration@thenationalcouncil.org

Phone: 202.684.7457

www.integration.samhsa.gov

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

SAMHSA

Policy 21.19 – Psychosocial Rehabilitation-Individual (PSR-I)

I. POLICY:

A. The goal of ACR's Psychosocial Rehabilitation Program is recovery. As such, recovery results in the restoration of each individual's ability to live independently, interact in social setting and use tools to manage life effectively. All interventions within the ACR's Psychosocial Rehabilitation Program facilitate the process of recovery. Personal responsibility for each individual is promoted and reliance on traditional psychiatric services is reduced. Community integration is fostered through the teaching of skills that will allow individuals to participate in educational, social, vocational and therapeutic opportunities in their community of choice.

1. To provide an array of services to persons with a primary diagnosis of mental illness.
2. To maximize consumer involvement, preference, choice, and empowerment through active consumer involvement in treatment planning, self-advocacy and program development.
3. To provide community support activities which empower consumers by promoting self-management of symptoms, personal growth, independent living, recovery and use of natural supports and community resources.
4. To provide assessments, psychoeducational groups, individual counseling and case management services that promote optimal functioning and integration in the community and build upon a person's strengths to overcome or compensate for the negative effects of mental illness

II. PROCEDURES:

A. Psychosocial Rehabilitation-Individual (PSR-I) services consist of rehabilitative skills building, the personal development of environmental and recovery supports considered essential in improving a person's functioning, learning skills to promote the person's self-access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual. Activities of Psychosocial Rehabilitation-Individual include:

1. Providing skills support in the person's self-articulation of personal goals and objectives.
2. Assisting the person in the development of skills to self-manage or prevent crisis situations.
3. Individualized interventions in living, learning, working, other social environments, which shall have as objectives:
    a. Identification, with the person, of strengths which may aid him/her in achieving recovery, as well as barriers that impede the development of skills necessary for functioning in work, with peers, and with family/friends.
    b. Supporting skills development to build natural supports (including support/assistance with defining what wellness means to the person

in order to assist them with recovery-based goal setting and attainment).

c. Assistance in the development of interpersonal, community coping and functional skills (which may include adaptation to home, adaptation to work, adaptation to healthy social environments, learning/practicing skills such as personal financial management, medication self-monitoring, symptom self- monitoring, etc.).
d. Assistance in the acquisition of skills for the person to self-recognize emotional triggers and to self-manage behaviors related to the behavioral health issue.
e. Assistance with personal development, work performance, and functioning in social and family environments through teaching skills/strategies to ameliorate the effect of behavioral health symptoms.
f. Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the person's mental illness/addiction.
g. Assist the person in his/her skills in gaining access to necessary rehabilitative, medical, social and other services and supports.
h. Assistance to the person and other supporting natural resources with illness understanding and self-management (including medication self-monitoring).
i. Identification, with the individual and named natural supporters, of risk indicators related to substance related disorder relapse, and the development of skills and strategies to prevent relapse.

B. Psychosocial Rehabilitation-Individual (PSR-I) is provided in order to promote stability and build towards functioning in the person's daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in community/work activities. Supports based on the person's needs are used to promote recovery while understanding the effects of the mental illness and/or substance use/abuse and to promote functioning.

C. **Assessment:** At beginning of service each individual will be assisted in completing the Client's Assessment of Strengths, Interests and Goals (CASIG). CASIG is designed to be the principal assessment instrument for planning, evaluating, and modifying individual and programmatic rehabilitation treatment.

CASIG assesses six key areas of a consumer's life:

1. **Goals.** The consumer's goals for improved functioning during the next year are elicited with open-ended questions grouped into five major domains of community living; housing, financial-vocational, social-familial, religion, and physical-mental health. Except for slight variations in wording to fit a particular domain, the open-ended questions include:
    a. Would you like to improve your (functional domain) in the next year?
    b. How might you improve your (functional domain)?

c. What do you currently have (i.e., resources, experience, assets) to help you?
d. What help do you need to achieve your goal?

2. **Current functioning.** The consumer's current performance of the skills of nine domains of functioning are assessed with from four to nine closed-ended questions in each domain. The nine domains include money management, health management, friends, leisure, vocational, personal hygiene, care of personal possessions, nutrition, and transportation. The client is also asked if s/he would like to make it a personal goal to improve his/her performance in each domain.
3. **Medication Practices.** The client's attitude toward his/her psychoactive medication is assessed with six closed-ended questions and two open-ended questions about his/her knowledge of the names and effects of his/her medications. The client is also asked about the presence/absence of each of 18 side effects, and his/her wish to learn more about medications and be responsible for administering them.
4. **Quality of Life and Treatment.** The client is asked to rate each of 10 qualities of his/her life (e.g., "the money you have") and 11 qualities of his/her treatment (e.g., "psychiatrist explains treatment") on a 4 point scale (poor, fair, good, excellent).
5. **Symptoms.** The client is asked a set of questions to determine the presence/absence of each of six symptoms; anxiety, depression, suicidality, hallucinations, delusions, and mania. The goal is to detect impending symptomatic relapse and, if that is indeed the case, confer with the client's psychiatrist to specify the actions for averting the relapse. The criteria for conferring with the client's psychiatrist are deliberately biased to identify false positives so that the much more costly false negatives can be avoided. The client is also asked if s/he would like to make it a personal goal to control any symptom(s) s/he experiences.
6. **Unacceptable Community Behaviors.** The client is asked about his/her performance of 10 unacceptable behaviors such as use of illegal street drugs, excessive alcohol consumption, verbal assault, physical assault, and property destruction. The intent is to determine if the client has performed a behavior that might represent a risk to the community.

D. Treatment Planning: The results of the CASIG are reviewed by the therapist and discussed with the individual to jointly determine how to best enhance strengths identified and to develop a plan to improve upon deficits identified. The needs identified are used to develop an Individual Recovery Plan (IRP) in coordination with the individual and if appropriate their family. IRP's are updated at regular intervals or whenever a marked change occurs.

E. Treatment Practices:

1. UCLA Social & Independent Living Skills program
2. The Boston University Psychiatric Rehabilitation Approach
3. Dual Facing Work Advisors Project (DFWA) (Prospectus) Job Readiness Toolkit
4. Learning-Based Procedures Used in Social Skills Training

a. "Problem identification" is made in collaboration with the patient in terms of obstacles that are barriers to a patient's personal goals in his/her current life
b. "Goal setting" generates short-term approximations to the patient's personal goals with specification of the social behavior that is required for successful attainment of the short-term, incremental goals. The goal-setting endeavor requires the therapist or trainer to elicit from the patient detailed descriptions of what communication skills are to be learned, with whom are they to be used, where, and when
c. Through "role plays" or "behavioral rehearsal," the patient demonstrates the verbal, nonverbal, and paralinguistic skills required for successful social interaction in the interpersonal situation set as the goal
d. "Positive" and "corrective feedback" is given to the patient focused on the quality of the behaviors exhibited in the role play
e. "Social modeling" is provided with a therapist or a peer demonstrating the desired interpersonal behaviors in a form that can be vicariously learned by the observing patient
f. "Behavioral practice" by the patient is repeated until the communication reaches a level of quality tantamount to success in the real-life situation
g. "Positive social reinforcement" is given contingent on those behavioral skills that showed improvement
h. "Homework assignments" are given to motivate the patient to implement the communication in real-life situations
i. "Positive reinforcement" and "problem solving" is provided at the next session based on the patient's experience using the skills

F. ACR's Case Management Services consist of four (4) major components that cover multiple domains that impact one's overall wellness including medical, behavioral, wellness, social, educational, vocational, co-occurring, housing, financial, and other service needs of the individual:

1. Engagement & Needs Identification

The case manager engages the individual in a recovery-based partnership that promotes personal responsibility and provides support, hope, and encouragement. The case manager assists the individual with developing a community-based support network to facilitate community integration and maintain housing stability. Through engagement, the case manager partners with the individual to identify and prioritize housing, service and resource needs to be included in the IRP.

2. Care Coordination

The case manager coordinates care activities and assists the individual as he/she moves between and among services and supports. Care coordination requires information sharing among the individual, his/her core provider, specialty provider(s), residential provider, primary care physician, and other identified supports in order to:

1) Ensure that the individual receives a full range of integrated services necessary to support a life in recovery that includes health, home, purpose, and community.
2) Ensure that the individual has an adequate and current crisis plan.
3) Reduce barriers to accessing services and resources.
4) Minimize disruption, fragmentation, and gaps in service.
5) Ensure all parties work collaboratively for the common benefit of the individual.

3. Referral & Linkage

The case manager assists the individual with referral and linkage to services and resources identified on the IRP including housing, social supports, family/natural supports, entitlements (SSI/SSDI, Food Stamps, VA), income, transportation, etc. Referral and linkage activities may include assisting the individual to:

1) Locate available resources
2) Make and keep appointments
3) Complete the application process
4) Make transportation arrangements when needed.

4. Monitoring and Follow-Up

The case manager visits the individual in the community to jointly review progress made toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the individual in order to:

1) Determine if services are provided in accordance with the IRP.
2) Determine if services are adequately and effectively addressing the individual's needs.
3) Determine the need for additional or alternative services related to the individual's changing needs or circumstances.

Notify the treatment team when monitoring indicates the need for IRP reassessment and update.

5. Treatment Plan

The foundation of case management is an ongoing, person-centered individual recovery plan. ACR administers a battery of assessment to determine to identify areas of need, deficits, personal resources and strengths and goals. Our assessments include the BioPsychoSocial Assessment, Psychiatric Diagnostic Assessment, Nursing Assessment, Client's Assessment of Strengths, and Goals (CASIG), Substance Abuse

Assessment and Vocational Rehabilitation Assessment. The needs identified in these assessment are used to develop an Individual Recovery Plan (IRP) in coordination with the individual and if appropriate their family. IRP's are updated at regular intervals or whenever a marked change occurs. Case managers will be familiar with IRP for the individuals on their caseload IRP in order to provide assistance as necessary to support the individual in achieving their recovery goals.

G. Crisis Planning and Support of Individuals in Crisis

1. Crisis Plans will developed for all individuals in recovery so the individual, families and other supporters as applicable will know what how to respond if the individual experiences a crisis.
2. ACR Policy 21.06 (Crisis Intervention) provides guidance on how a crisis will be handle by the agency. Psychosocial Rehabilitation staff shall familiarize themselves the Crisis Intervention Policy. The therapist assigned to the individual's case will coordinate the response to an individual's crisis. Psychosocial Rehabilitation staff will contact the therapist for guidance on how to deal with the crisis and provide support as requested.

III. TRAINING AND SUPERVISION OF CASE MANAGERS:

All case managers will be trained in The Principles of Multicultural Psychiatric Rehabilitation Services.

References:

21.19a - The Principles of Multicultural Psychiatric Rehabilitation Services

Annex 21.19a - Principles Of Multicultural Psychiatric Rehabilitation Services

Principle 1: Psychiatric rehabilitation practitioners recognize that **culture is central, not peripheral, to recovery**, as culture is the context that shapes and defines all human activity.

Principle 2: Psychiatric rehabilitation practitioners study, understand, accept, and appreciate their own cultures as a basis for relating to the cultures of others.

Principle 3: Psychiatric rehabilitation practitioners **engage in the development of ongoing cultural competency**, in order to increase their awareness and knowledge, and to develop the skills necessary for appropriate, effective cross-cultural interventions.

Principle 4: Psychiatric rehabilitation practitioners recognize that **thought patterns and behaviors are influenced by a person's worldview, ethnicity and culture**, of which there are many. Each worldview is valid and influences how people perceive and define problems; perceive and judge the nature of help given; choose goals; and develop or support alternative solutions to identified problems.

Principle 5: Psychiatric rehabilitation practitioners recognize that discrimination and oppression exist within society; these take many forms, and are often based on perceived differences in color, physical characteristics, language, ethnicity, gender, gender identity, sexual orientation, class, disability, age, and/or religion. Psychiatric rehabilitation practitioners play an active role and are **responsible for mitigating the effects of discrimination associated with these barriers** and must advocate, not only for access to opportunities and resources, but also for the elimination of all barriers that promote prejudice and discrimination.

Principle 6: Practitioners **apply the strengths/wellness approach to all cultures**.

Principle 7: Psychiatric rehabilitation practitioners show respect towards others by **accepting cultural values** and beliefs that emphasize process or product, as well as harmony or achievement. They demonstrate that respect by appreciating cultural preferences that value relationships and interdependence, in addition to individuality and independence.

Principle 8: Psychiatric rehabilitation practitioners accept that **solutions to any problem are to be sought within individuals, their families (however they define them), and their cultures**. The person using psychiatric rehabilitation services and his/her family are sources of expanding the practitioner's knowledge about that culture, how to interpret behaviors, and how to integrate these cultural perspectives into a rehabilitation/recovery plan. Alternatives identified by service providers are offered as supplementary or educational, rather than compulsory.

Principle 9: Psychiatric rehabilitation practitioners **provide interventions that are culturally syntonic**, and accommodate culturally determined strengths, needs, beliefs, values, traditions, and behaviors.

Principle 10: Psychiatric rehabilitation practitioners are responsible for **actively promoting positive inter-group relations**, particularly between the people who attend their programs and with the larger community.

Policy 21.21 – Peer Support - Individual

I. POLICY:

A. ACR offers a variety of the Peer Support services to assist individuals throughout their recovery process. Peer Support - Individual services actively support persons with mental illness in making meaningful choices about their treatment, housing, education, employment and social activities. Because individuals are motivated by the hope that it will be possible one day to lead an independent life, peer support programs foster self-determination by focusing on teaching skills needed to direct one's own life. This emphasis on self-management in peer support encourages people to take responsibility for their life and illness in an affirming manner. By exercising self- determination, program members become active partners in their efforts to lead productive lives and make significant contributions to the communities in which they live.

B. ACR is committed to being a recovery-oriented mental health system embraces the following values:
   1. Self-determination.
   2. Empowering relationships.
   3. Meaningful roles in society.
   4. Eliminating stigma and discrimination.

C. It is our belief in order build a recovery-based system, ACR must draw upon the resources of people with mental illness within communities; and is support of our belief, we will engage the services of Georgia Certified Peer Specialists (CPS) to assist us as agency, be role models for recovery, advocate for the recovery needs of individuals with mental illness/substance abuse and provide services to those in recovery.

D. CPS's are integral part of our recovery teams with same rights and responsibilities of other team members.

II. PROCEDURES:

A. Peer Support Services are structured and scheduled activities for adults age eighteen (18) and older with a MH/SA disability. Peer Supports are provided Georgia-Certified Peer Specialist (CPS). Peer Support – Individual is a one-on-one recovery-focused service that allows individuals the opportunity to learn to manage their own recovery and advocacy process. Interventions provided by the CPS serve to enhance the development of natural supports, as well as coping and self-management skills. Interventions of Peer Support staff may also provide supportive services to assist an individual in community re-entry following hospitalization.

B. Peer Support – Individual emphasizes personal safety, self worth, confidence, and growth, connection to the community, boundary setting, planning, self advocacy, personal fulfillment, and development of social supports, the helper principle, and effective communication skills. Services emphasize the acquisition, development, and expansion of rehabilitative skills needed to move forward in recovery.

C. Examples of specific interventions include:
    1. Self Help: Cultivating the individual's ability to make informed, independent choices. Helping the individual develop a network of contacts for information and support based on experience of the CPS.
    2. System Advocacy: Assisting the individual to talk about what it means to have a mental illness to an audience or group. Assisting the individual with writing a letter or making a telephone call about an issue related to mental illness or recovery.
    3. Individual Advocacy: Discussing concerns about medication or diagnosis with the Physician or Nurse at the individual's request based on experience of the Peer Support staff. Helping the individual make appointments for psychiatric and general medical treatment when requested. Guiding the individual toward a proactive role in health care.
    4. Pre-Crisis and Post Crisis Support: Assisting the individual with the development of a personal crisis plan, and/or a Psychiatric Advance Directive (PAD). This includes help in developing the Wellness Recovery Action Plan (WRAP). Giving feedback to the individual on early signs of relapse and how to request help to prevent a crisis. Assisting the individual in learning how to use the crisis plan. Supporting the individual in seeking less restrictive alternatives to locked hospital facilities and Emergency Department evaluations.
    5. Housing: Assisting the individual with learning how to maintain stable housing through bill paying, cleaning, and organizing his or her belongings. Assisting the individual in locating improved housing situations. Teaching the individual to identify and prepare healthy foods according to cultural and personal preferences of the individual and his/her medical needs.
    6. Education/Employment: Assisting the individual in gaining information about going back to school or job training. Facilitating the process of asking an employer for reasonable accommodation for psychiatric disability (mental health day, flex time, etc).
    7. Social Activities: Assist individual in finding and learning the skills to participate in enjoyable social activities in the individual's community of choice.

D. Peer Support – Individual services are provided in 1:1 CPS to person-served ratio

E. All individuals in treatment will be offered and opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.

F. Peer Support – Individual services do not operate in isolation from the rest of the programs within ACR. The CPS is an integral member of each individual's recovery team.
    1. The CPS are be empowered to convene multidisciplinary team meetings regarding a participating individual's needs and desires.
    2. The CPS is an equal practitioner partner with all staff in multidisciplinary team meetings.

3. The CPS has the unique role as an advocate to the person-served, encouraging that person to participate in Individual Recovery Plan development and reviews so the individual's desires for recovery are known and the IRP goals and objectives reflects the individual's choice.
4. The CPS will review the IRP to ensure that the IRP supports recovery and independence and when the IRP does not meet this standard, the CPS will inform the team lead for corrective action.

G. The CPS assists individuals in:
   1. Wellness Recovery Action Plan (WRAP)
   2. Education
   3. Self-advocacy.
   4. Building a strong support system.

III. TRAINING:

A. Critical Knowledges and Evidence-Based Practices:
   All CPSs providing individual services must be able to articulate an understanding of and must demonstrate the skills and ability to assist other individuals in their own recovery processes:
   1. Recovery as defined by SAMHSA.
   2. Psychiatric rehabilitation principles published by United States Psychiatric Rehabilitation Association (USPRA) (Annex 21.19b).
   3. CPS will also be knowledgeable of the Empowerment Model of Recovery from Mental Illness.
   4. Person Centered Recovery Planning..
   5. Motivational Interviewing
   6. Stages of Change

B. All staff will be provided training on The 10 Fundamental Components of Recovery as outlined in National Consensus Statement On Mental Health Recovery, SAMSHA Pamphlet (Annex 21.19a):
   1. Self-Direction
   2. Individualized and Person-Centered
   3. Empowerment
   4. Holistic
   5. Non-Linear
   6. Strengths-Based
   7. Peer Support
   8. Respect
   9. Responsibility
   10. Hope

IV. Supports for CPS

A. All ACR CPSs will be given an opportunity to participate in a monthly CPS staff meeting to discuss issues of concern and provide support to each other.
   1. The CPS will decide upon themselves which CPS will serve a meeting chairperson, independently decide on the agenda for each meeting and report to the CEO directly on any issues that needs to be addressed provide better support for the CPS or individuals receiving services.
   2. CPS will be given opportunities to encourage and support to participate in trainings, meetings, etc. external to ACR that will improve their performance or job knowledge.

References:

21.20.a – National Consensus Statement on Mental Health Recovery, SAMSHA Pamphlet

21.20.b - United States Psychiatric Rehabilitation Association (USPRA) 12 Core Principles and Values

21.20.c - USPRA Principles of Multicultural Psychiatric Rehabilitation Services - Executive Summary

Policy 21.22 - Clinical Supervision

I. POLICY:

A. It is the policy of ACR to maintain a well-structured clinical supervision system, designed and maintained in a manner that enhances the skills and abilities of the supervised employees, and results in an increase in the quality of services provided. In addition, it is the policy of ACR to utilize the supervision process, along with the corporate compliance program, to ensure that all ethical and confidentiality policies and procedures are being met consistent with all legal, regulatory, and accreditation guidelines. A variety of methods will be utilized to maintain a well-structured supervisory system that includes direct observation, individual meetings, chart reviews, performance evaluations, and facilitation of a peer review process.

II. PROCEDURES:

A. The ACR supervisory system will be configured as follows:

1) The direct supervision of the clinical staff will be the responsibility of the designated ACR Clinical Supervisor.

2) The Clinical Supervisor will be supervised by, and report directly to CEO.

3) The Clinical Supervisor will carry a reduced direct care caseload to ensure all supervisory duties are completed in a timely manner, and there is ample time to provide quality supervision of benefit to the employee, and also ultimately benefiting the care of the patient and the organization's performance.

B. Documented ongoing supervision of clinical or direct service personnel addresses, when applicable:
   1) Accuracy of assessment and referral skills.
   2) The appropriateness of the treatment or service intervention selected relative to the specific needs of each person served.
   3) Treatment/service effectiveness as reflected by the person served meeting his or her individual goals.
   4) The provision of feedback that enhances the skills of direct service personnel.
   5) Issues of ethics, legal aspects of clinical practice, and professional standards, including boundaries.
   6) Clinical documentation issues identified through ongoing compliance reviews.
   7) Cultural competency issues.

C. The components of the counseling supervision process are as follows:

1) **Direct Observation:** All observed behavior and interactions involving the clinical staff within their roles and responsibilities are utilized in the supervisory process. Interactions with other staff, persons served, family members, and visitors that are observed by the Clinical Supervisor serve as information sources that can be used within the individual supervisory process. Such things as tone of voice, language use, and non-verbal behaviors are observed and serve as potential indicators of skills and abilities for supervisory discussion, feedback, and possible counselor performance improvement.

2) **Individual Supervision**: Individual supervision occurs on a monthly basis, with the Clinical Supervisor meeting individually with each counselor for a one-hour supervision session on a regularly scheduled day of the month. The individual supervision sessions contain one or more of the following activities:

    a. Review of Caseload: Review of the counselor's caseload, the caseload mix, and any specific issues regarding the size and mix of the caseload that either party deems important to discuss to support patient care.

    b. Case Review: Review of an individual person served and case record to discuss assessments, treatment planning, interventions, progress, counseling interventions, and to generate ideas for alternative approaches or an increase or decrease in a particular method or approach to counseling.

    c. Performance Evaluation: Review and discussion of the clinical staff's annual performance evaluation, at the time of required annual completion, or when referencing during the evaluation year for assessing the level goals and objectives listed on the evaluation are being met.

    d. Miscellaneous and/or Acute Issues: Review of both acute patient related situations that can support the counselor in their job performance and/or review of acute counselor performance related issues that may detract from the quality of patient care.

3) **Group Supervision**: Components of the group supervision process are as follows:

    a. Clinical Staff Meetings: Meetings with the clinical staff will occur every other week on a regular scheduled day, at a regularly scheduled time. The purpose of the meeting is to utilize a team approach to care through the discussion of policy, procedures, and clinical approaches, in-service "counselor specific" training, and review and discussion of individual patient's program status in a manner that supports the care of the patient.

b. Peer Patient Record Review: The clinical staff will meet on a quarterly basis to participate in a review of patient records. The Clinical Supervisor will facilitate the review by providing an agenda, guidance in the components of the review and each person's responsibility in participation, and education and training consistent with the outcome of the case reviews.

D. The components of the Clinical Supervisor's responsibilities are as follows:

1) **Scheduling, Conducting, and Documenting Individual Supervision Sessions**: Documentation of the supervisory meetings will be contained on the ACR Individual Supervision Form. The form will contain the following information resulting from the session:

a. The date of the session.

b. The time of the session.

c. The name of the supervisee.

d. A description of the topics, issues, and process.

e. Any new expectations of performance to be met that resulted from the discussion of acute events and behavior.

f. Any information related to progress with meeting the goals and objectives noted on an individual's performance evaluation.

2) **Review of Individual Case Records:** Prior to meeting with an individual, the Clinical Supervisor may review one or more files to determine the current level of the quality of documentation in a chart, and/or to assist a supervisee with managing a challenging set of circumstances related to a patient's needs and preferences.

3) **Completion of The Annual Performance Evaluation and Review With Employee**: This process will involve:

a. Completing the evaluation form by scoring the specific indicators of performance related to the employee's job duties.

b. Meeting with the employee to determine and negotiate job performance goals and objectives based on specific job duty areas needing improvement.

c. Reviewing the previous year's goals and objectives to determine the level in which they were met.

d. Determining specific training and supervision methods to support the noted performance goals and objectives.

e. Obtaining the employee's signature, signing the form, and ensuring that the human resource designee gets the form and places it in the employee's personnel file.

4) **Facilitation of the Peer Record Review Meeting and Process:** The Clinical Supervisor will conduct the quarterly Peer Record Review meeting and process according to the procedures contained within ACR's established policy for the review.

5) **Communication of Counseling Supervision Information to The Executive Director**: The Clinical Supervisor meets on a monthly basis with the Executive Director (or designated supervisor) and provides the following information within the meeting:

a. Caseload levels and mix.

b. Information related to counselor staffing levels and needs.

c. Recommendations for creating, revising, or eliminating policy, procedures, and practice guidelines.

d. Level of counselor performance, consistent with performance evaluation results.

e. Other information related to counseling services and direct patient care that may impact the quality of care and/or the risk of loss exposure to the organization.

f. Recommendations for new hires.

6) **Dissemination of Information at The Management Team Meeting:** The Clinical Supervisor is responsible for reporting all information related counseling services that may be relevant in the ongoing management of the organization. Information can include, but not limited to:

a. Caseload levels and mix

b. Staffing levels and needs

c. Counseling and clinical policy and procedure revisions

d. Implementation of new practices, results of the peer review process

e. Results of performance improvement related to direct patient care in the areas of effectiveness of treatment and satisfaction of patient's with services.

f. Critical Incidents or situations impacting patient care and risk of loss exposure.

g. Coordination of clinical services with other disciplines.

Policy 22.01 - Screening and Access to Services

I. POLICY:

It is the policy of ACR to only admit individuals whose needs can be met by the ACR's behavioral health program. In an effort to reduce the stress, stigma, and strain often encountered when trying to obtain treatment, ACR begins the screening process upon the initial phone call, and commits to scheduling the first appointment within one business day of the inquiry.

II. PROCEDURES:

A. Initial screening is performed by any ACR employee, contract counselor, or volunteer intern, and involves determining whether or not the needs of the individual involved dictates the need of scheduling an appointment with a licensed/ certified practitioner.

B. The following individuals are the priority for ongoing support services These individuals once it has been determined they meet core customer as detailed in DBHDD Provider Manual for the current fiscal year must be seen:

   1) within 2 hours of contact if in crisis
   2) within 24 hours for emergent problems
   3) within 5 days from application or referral for services for routine needs.

C. The first priority group for services is individuals currently in a state operated psychiatric facility, state funded/paid inpatient services, a crisis stabilization or crisis residential program.

D. The second priority group for services is:

   1) Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years
   2) Individuals with a history of one or more crisis stabilization program admissions within the past 3 years
   3) Individuals with a history of enrollment on an Assertive Community Treatment team within the past 3 years
   4) Individuals with court orders to receive services
   5) Individuals under the correctional community supervision with mental illness or substance use disorder or dependence

6) Individuals released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence
7) Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate.
8) Pregnant women
9) Individuals who are homeless
10) IV drug1 Users

E. During the initial phone call, individuals are informed of any session charges and/or ACR participation status with their insurance company. If the client is unsure of who their mental health/ substance abuse carrier is, they are asked to bring their insurance card to the initial session for verification of benefits.

F. Admissions are conducted by Intake Coordinator/Designee.

G. The initial determination of an individual's appropriateness for all services shall include at minimum:
1) A description of the client's presenting problem
2) A review of an individual's need for services
3) Legal eligibility criteria if applicable (i.e. level of treatment as mandated by court)
4) Availability of funding sources
5) An interview with the potential client or referral source
6) Documentation of any urgent needs of person served

H. When an individual is found not eligible for services:
1) The person is informed as to the reasons
2) The referral source is informed as to the reasons, if consent is obtained
3) Recommendations for alternative services are made
4) Documentation is maintained

I. Intake Personnel and Assessors must be knowledgeable of ACR programs and eligibility for service requirements. Detailed information on ACR programs is provided in:
1) Policy 21.01 - Assertive Community Recovery Adult Behavior Health Programs
2) Policy 21.02 - Brief Stabilization and Core Recovery Program

3) Policy 21.03 - Assertive Community Treatment Program Plan
4) Policy 21.04 - Peer Support Program Plan

J. In the event that the client to staff ratio exceeds the limits set forth in the Policies and Procedures, ACR shall make arrangements to hire contract staff until more permanent arrangements can be made.

K. Whenever individuals present themselves for service and ACR has exceeded its capacity in the program needed, a wait list will be maintained in accordance with ACR Policy 22.06, Wait List.

L. ACR's Clinical Director, in consultation with the appropriate psychiatrist, makes the final determination concerning the appropriateness of a individual entering into a particular ACR program/service. ACR's Clinical Director, in consultation with the appropriate psychiatrist, is also responsible to make the final determination when a individual's recovery needs exceeds ACR's ability to provide and to make an appropriate referral.

Policy 22.02 - Assessment

I. POLICY:

A. It is the policy of ACR to provide a comprehensive psychosocial assessment upon admission to any service program. The purpose of the psychosocial assessment is to identify the individual's principal reasons for seeking services, to clarify needs and preferences, and to identify conditions that shall constitute the focus of the services provided.

II. PROCEDURES:

A. A comprehensive psychosocial assessment will be completed for all individuals served by ACR, regardless of the level of care or the type of program in which the individual is enrolled.

B. The results of the initial psychosocial assessment process will be used to assist in the development of the individual treatment plan for all persons served.

C. Initial assessments will be completed within the first three sessions, or first three days of treatment, depending on the program setting.

D. Assessments will contain, at a minimum, the following information:

a) The individual's strengths, abilities, needs, preferences, attitudes, interests and skills.

b) Presenting problems

c) Previous behavioral health history

d) Physical health history and current status

e) Diagnosis

f) Mental status, cognitive functioning, emotional functioning, and behavioral functioning

g) Current and historical life information including age, gender, sexual orientation, cultural background, spiritual beliefs, employment history, legal involvement, family history, history of abuse, and relationships

h) Use of alcohol, tobacco, and/or other drugs

i) Need for, and availability of, social supports

j) Risk-taking behaviors

k) Level of educational functioning

l) Advance directives, when applicable

m) Medication-use profile

n) Medication allergies or adverse reactions to medications

o) Adjustment to disorders/disabilities

p) Assessment for suicide risk using the Columbia Suicide Severity Rating Scale (CSSRS) that is appropriate for the individual. See ACR Policy 22.07 -Suicide Risk Assessments.

E. Requests for previous diagnostic reports and relevant records will be made at the time of the initial assessment. All copies of previous records will be placed in the current individual record and will be integrated into the assessment process.

F. All assessments will be continually updated whenever a significant change occurs in an individual's treatment or program status, such as accomplishment of significant goals.

G. The initial and primary assessment shall result in an interpretive summary that serves the following purposes:

a) Utilizes the assessment data to integrate and interpret the information in a manner that provides an emphasis on the interrelationships between the sets of findings, contains clinical judgments regarding both positive and negative factors likely to affect the person's course of treatment and clinical outcomes, and provides the central themes present throughout the information gathered.

b) Is utilized in the development of the individual plan.

c) Identifies any co-occurring disabilities/disorders that should be addressed in the development of the individual plan.

H. All persons served who require additional assistance to complete the assessment process, due to disability or limitations, will be provided with the necessary support to do so within ACR's capacity to accommodate the special needs.

Policy 22.03 - Orientation of Persons Served

I. POLICY:

A. It is the policy of ACR to orient each person served to the organization and its programs in a manner that is understandable to the person served, and ensures that all persons served will have a functional awareness of the components of their the services to be provided. This process is designed to increase the ability of the person served to achieve maximum benefit from services.

II. PROCEDURES:

A. All persons who enter ACR programs will receive a comprehensive orientation, provided by the person coordinating their treatment, or a representative of the program assigned to provide the orientation.

B. The provider of the orientation will utilize a patient orientation checklist to ensure that all relevant components of orientation are systematically covered in the process.

C. Following a review of all items on the patient orientation checklist, the person served will be asked to sign the checklist indicating they have an understanding of the information presented, understand the program rules, and are fully aware of any restrictions or privileges that may be imposed due to a violation of the program rules.

D. The orientation includes an explanation covering the following service components:

1. Services provided

2. Days and hours of operation

3. Expected level of participation

4. Access to emergency services, after hours

5. Rights and grievance procedures

6. Confidentiality policy

7. Limits of confidentiality

8. Methods and opportunities to provide input

9. Financial obligations and fees

10. Safety and emergency evacuation procedures

11. Policy on restraint

12. Policy on tobacco products

13. Policy on legal or illegal drugs on clinic premises

14. Policy on weapons

15. Person responsible for service coordination

16. Purpose and process of psychosocial assessment

17. Purpose and process of the individual plan

18. Discharge/transition criteria and procedures

E. All service providers conducting patient orientation will complete an initial training in this area, as part of their clinical services supervision, to ensure all employees are providing orientations in a consistent manner.

Policy 22.04 - Accurate Identification of Individuals Served

I. POLICY:

It is the policy of Assertive Community Recovery positively and accurately identify all individuals participating in our programs to ensure that care is provided to the correct the individual during all phrases of treatment, service delivery, medication management and medication administration. This practice effectively reduces incidents and near misses relating to patient care and undertakes to support safer patient care through effective patient identification before care delivery.

II. PROCEDURES:

1. Within the community setting, large numbers of patients and clients receive care in a variety of settings, i.e. ACR office, clinics, peer support centers, private residences and group homes. Due to the variety of settings and in order to support and ensure patient safety it is paramount that the identity of the patient is confirmed prior to administration of medicine or delivery of care by the health professional.

2. The following guidance should be considered prior to care delivery:
    a. Check the patient identity verbally with the patient using their full name, confirming their date of birth and the purpose of the proposed care delivery.
    b. Where the patient is not able to confirm their identity due to their current health or mental capacity, confirm the patient identity with a known care giver.
    c. In all cases ensure the patient's privacy and dignity is maintained throughout the care procedure.
    d. Check the patient's records prior to administration of medication or care to ensure that you have the correct patient, at the correct time, for the correct procedure.

III. Responsibility of Managers

It is the responsibility of Managers to ensure all staff upon being placed in a position are made aware of this policy. Where staff are currently in their position, this policy will be cascaded through the policy implementation process and awareness raised at staff meetings.

IV. Monitoring

Implementation of this policy will be monitored by the Management Team via the Incident Reporting procedure.

V. Incident Reporting

Staff must report all patient safety incidents, including near misses, related to patients misidentification.

Policy 22.05 - Providing Adult Mental Health and Behavior Health Services and Treatment to Emancipated Minors and Individuals with Personal Representatives

Purpose: ACR must treat emancipated minors and the personal representative of an Individual in the same way that it would treat the Individual for purposes of consenting to treatment and complying with the HIPAA regulations.

DEFINITIONS:

Health Information: Any information whether oral or recorded in any form, that is created or received by ACR that relates to an Individual's past, present or future physical or mental health, or to the payment for such health care.

Individually Identifiable Health Information: Health Information, including demographic information, that identifies an Individual or with respect to which there is a reasonable basis to believe that the information can be used to identify an Individual.

Protected Health Information (PHI): Individually Identifiable Health Information that is transmitted by electronic media or transmitted or maintained in any other form or medium.

Emancipated Minor: Under Georgia law an emancipated minor is:

1. **18 years of age or older; or is married;**
   or
2. **Self-supporting and has been declared to be emancipated by the courts;**
   or
3. **In the armed services.**

POLICY:

A. General Rule:

1. ACR must treat emancipated minors and the personal representative of an Individual in the same way that it would treat the Individual for purposes of consenting to treatment and complying with the HIPAA regulations.
2. To participate in the adult mental and behavior services that ACR offers, an individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are

emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.

B. Determining Who Should Be Recognized as an Individual's Personal Representative:

1. **When an Individual is an Adult or Emancipated Minor:** If the Individual is an adult or emancipated minor, and if under applicable law a person has authority to act on behalf of the Individual in making decisions related to health care, then the ACR must treat such a person as the personal representative of the Individual with respect to PHI that is relevant to the personal representation.
2. **Determining Under Georgia Law Who Has Authority to Act on Behalf of an Individual in Making Decisions Related to Health Care:** Applicable Georgia law authorizes the following persons to consent to lawful surgical or medical treatment which may be recommended, prescribed or directed by a duly licensed physician:
    a. Any adult for him/herself whether by living will or otherwise.
    b. Any person authorized to give consent for an adult under a lawful Durable Power of Attorney for Health Care.

PROCESS:

Prior to recognizing any person as an emancipated minor or the personal representative of an Individual, ACR shall verify that the person has the authority to be an emancipated minor or serve as the Individual's personal representative and that no circumstances apply that should prohibit ACR from recognizing the person as an emancipated minor or the personal representative. In any situation requiring further guidance or clarification whether ACR should treat a individual as an emancipated minor the Regional BHDD office will be contacted for clarification and written guidance.

APPLICABILITY OF MINIMUM NECESSARY AND ACCOUNTING RULES:

HIPAA states that for adults and emancipated minors who have personal representatives who can act on their behalf in making decisions regarding health care, then PHI that is relevant to the subject matter of the personal representation may be disclosed. In general, personal representatives may have access to any PHI that may impact their health care decision-making. Because the personal representative stands in the place of the Individual under HIPAA, and accounting does not need to be made for disclosures to the Individual, the accounting rule does not apply.

Reference: 45 C.F.R. § 164.502(g).

Policy 22.06 - Wait List

ACR Health Services does not maintain wait lists.

It is core to our belief that individuals/families should receive immediate and responsive care. Therefore, in all cases whenever requests for service exceeds our abilities or capacity, ACR will assist the individual/family by making an appropriate referral that matches the needs of the individual/family.

Policy 22.07 -Suicide Risk Assessments

POLICY:

It is the policy of ACR to provide a suicide risk assessment upon admission to any service program. The purpose of the suicide risk assessment is to identify any risk factors that may indicate that the individual may be at risk for harming self or others. It is also the policy of ACR to provide a suicide risk assessment at anytime during treatment when risk factors are identified or self-disclosure is made.

PROCEDURE:

1. A suicide risk assessment is completed by the appropriate staff/contractor using the appropriate Columbia-Suicide Severity Rating Scale (C-SSRS) to document any concerns of risk by a staff member, regardless of the presence of a behavior, are to be assessed. All staff members who come into contact with individuals in seeking treatment will be trained the using the Columbia-Suicide Severity Rating Scales (C-SSRS) that is appropriate for their role in order to assess the severity and intensity of suicidal ideation and to document the full range of behaviors with a lethality measure for suicide attempts.

2. The assessor will determine low, medium or high risk based on the suicide risk assessment and information gathered by any collaterals involved.

   If there is **high risk**, the individual will be escorted to the nearest emergency; however, if there is immediate concern for safety, the individual will be escorted by police to the nearest emergency room.

   If **moderate risk** has been determined and the individual is not able to contract for safety, that individual will be referred for further evaluation at the nearest emergency room.

   If **moderate risk** has been determined and the individual is able to contract for safety and there is no immediate harm, appropriate safe guards are put into place to include: safety plan/no harm contract, increased sessions with therapist, family members are identified to ensure safety

   If **history only** defined as no suicidal ideation withing the past month and suicidal behavior more than three months ago, assess and determine what steps are necessary for safety. Provide education, develop safety and crisis plans, link with natural supports, family members, teach coping skills and increased sessions with therapists.

   If **low risk** has been determined and there is no plan, intent, and no risk factors, individual will be monitored/assessed by appropriate staff until there is no risk.

3. Individuals determined to be high risk, moderate risks and by history only will be assessed by an appropriate licensed staff member to determine the nature and history of individual's self-harm tendencies and to develop an comprehensive plan for treatment. ACR Suicide Risk Assessment (Form 22.07a) will be used to document this assessment.
4. The assessor will document in the individual's chart to reflect all interventions that occurred during the suicide risk assessment process. All staff/contractor involved with case will be notified via case staffing format.
5. The assessor will make report to Clinical Director who will ensure incident report is completed and information forward to QI committee.

Forms:

21.06.a - Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment - Adult
21.06.b - Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime Recent - Clinical
21.06.c - Columbia-Suicide Severity Rating Scale (C-SSRS) Since Last Visit - Clinical
21.06.d - Columbia-Suicide Severity Rating Scale (C-SSRS) Pediatric/Cognitively Impaired – Lifetime Recent - Clinical
21.06.e - Columbia-Suicide Severity Rating Scale (C-SSRS) Pediatric/Cognitively Impaired - Since Last Visit - Clinical
21.06.f - Columbia-Suicide Severity Rating Scale (C-SSRS) - Clinical Practice Screener -Recent
21.06.g - Columbia-Suicide Severity Rating Scale (C-SSRS) Clinical Practice Screener - Since Last Visit
22.07.a – ACR's Suicide Risk Assessment Form

Suicide Risk Assessment and Referral Record

Individual Name

Last First Middle Initial

Medicaid Number:

Assessment Date:

This assessment is based on information collected from the following sources:
☐ My Interview with the following:
☐ Individual:
☐ Family Members:
☐ Friends:
☐ Others:
☐ Review of Records (specify)
☐ Other sources:

Current Mental Status	
☐ Suicidal Ideation by client	☐ Realistic plan in hospital
☐ Suicidal ideation alleged by others	☐ Suicidal intent alleged by others
☐ Realistic plan in community	☐ Suicidal intent expressed by client

Clinical Factors	
☐ Severe Anxiety and/or agitation	☐ Obsessive-Compulsive Disorder
☐ Anorexia Nervosa	☐ Schizophrenia
☐ Bipolar II	☐ Paranoid or Undifferentiated Type
☐ Mixed State	☐ Depressive State
☐ Depressive phase of illness	☐ Command Hallucinations
☐ Depression	☐ More than a high school education
☐ Severe	☐ Less than 40 years olds
☐ Anhedonia or hopelessness	☐ Personality Disorder

- ☐ Anxiety, agitation, or panic
- ☐ Aggression or impulsivity
- ☐ Delusional thinking
- ☐ Global or partial insomnia
- ☐ Recent sense of peace/well-being
- ☐ Recent sense of peace/well-being
- ☐ Co-morbid alcohol abuse/dependence
- ☐ Dysthymia
- ☐ Post Partum Depression
- ☐ Alcohol/Substance Abuse/Dependence
  - ☐ Co-morbid Axis I Disorder
  - ☐ Mixed Drug Abuse
  - ☐ Cluster B or Cluster C
  - ☐ Co-morbid depression
  - ☐ Co-morbid alcohol abuse/dependence
- ☐ Epilepsy
  - ☐ Temporal lobe epilepsy
- ☐ Chronic Pain
- ☐ More than one psychiatric diagnosis
- ☐ Currently psychotic
- ☐ Unstable or poor therapeutic relationship

Loss Factors

- ☐ Decrease in vocational status
- ☐ Loss of significant relationship
- ☐ Decline in physical health
- ☐ Loss of freedom due to legal status

Cognitive Features that Contribute to Risk

- ☐ Loss of executive function
- ☐ Thought constriction (tunnel vision)
- ☐ Polarized thinking
- ☐ Closed-mindedness
- ☐ Inability to adapt to a dependent role

Historical Factors

- ☐ Prior suicide attempts
- ☐ Family history of suicide
- ☐ Anniversary of important loss
- ☐ Impulsivity
- ☐ Family of origin violence
- ☐ Victim of physical or sexual abuse
- ☐ Suicidal intent expressed by client

Demographic Factors

- ☐ Male
  - ☐ 65 Years or older
  - ☐ 85 Years or older
- ☐ Low socioeconomic status
- ☐ Living alone
- ☐ Living alone
- ☐ Caucasian or Native American
- ☐ Unemployed
- ☐ Access to/history of use of firearms
- ☐ Lack of structured religion

Risk Reduction Factors

☐ Pregnancy	☐ Employed
☐ Responsible for children under 18 years old	☐ Living with another person, especially a relative
☐ Sense of responsibility to family	☐ Positive social support
☐ Catholicism or Judaism is religion of choice	☐ Positive therapeutic relationship

Individual Risk Reduction Factors and Individual Risk Factors:

(Describe areas of family education needs. Family education must be directed to the exclusive needs of the client.)

Clinician's Formulation of Risk::

(Using the risk factors and risk reduction factors identified above, describe your estimation of the client's imminent and long term risk for suicide, as well as necessary interventions to assure client's safety and facilitate stabilization. Describe your clinical reasoning in detail.)

Interventions:

(Document interventions which directly address mitigating those risk factors which are identified and can be addressed either clinically or with the help of natural supports. For clients where a formal crisis plan is developed, that may serve to complete this section by attaching a copy of that plan.)

Assessor Signature: Date:

Name Credentials

22.08 – Children and Adolescents Standards

Purpose: It is the policy of Assertive Community Recovery, LLC (ACR), to provide programs for children and adolescents that consist of an array of behavioral health services designed specifically to address the treatment needs of children and adolescents. ACR program services are tailored to the particular needs and preferences of children and adolescents and are provided in a setting that is both relevant to and comfortable for this population.

POLICY:

A. General Rule:

(Refer to ACR Policy: 22.09 – Assessment of Children and Adolescents)

1. Assessments of each child or adolescent served include information on his or her:
    a. Developmental history, such as developmental age factors, motor development, and functioning.
    b. Medical or physical health history
    c. Culture/ethnicity.
    d. Treatment history.
    e. School history
    f. Language functioning, including:
        i. Speech functioning
        ii. Hearing functioning
    g. Visual functioning.
    h. Immunization record.
    i. Learning ability.
    j. Intellectual functioning.
    k. Family relationships.
    l. Interactions with peers.
    m. Environmental surroundings.
    n. Prenatal exposure to alcohol, tobacco, or other substances.
    o. History of use of alcohol, tobacco, or other substances.
    p. Parental/guardian custodial status.
    q. When applicable, parent's/guardian's:
        i. Ability /willingness to participate in services.
        ii. Strengths
        iii. Preferences

2. The assessments are appropriate with respect to the child's or adolescent's:.
    a. Development.
    b. Culture.
    c. Education.
3. When/if services disrupt the child's/Adolescents day-to-day educational environment, ACR makes arrangements for the continuity of his/her education through:
    a. Coordination with school system
    b. Coordination with the community school to facilitate reintegration
4. Based on the needs of each child or adolescent, or as required by law, an educational specialist is a member of the system of care team.
5. Based on the needs of the children or adolescents served, the program includes the development of:
    a. Community living skills.
    b. Social skills
    c. Social supports
    d. Vocational skills
6. The environment is configured appropriately to meet the needs of children and adolescents, including {refer to Agency Plan: 1.04L Accessibility Plan):
    a. The physical plant
    b. The furniture
    c. The equipment.
7. The organization implements a policy and procedures for (refer to ACR Policy: 10.13 - Verification of Credentials and Background Checks):
    a. Obtaining complete background checks on all persons providing direct services to children or adolescents.
    b. Acting on the results of the background checks.
8. The program does not exclude children or adolescents from services solely on the basis of their juvenile justice status.

22.09 -Assessment of Children and Adolescents

Purpose: It is the policy of Assertive Community Recovery, LLC (ACR), to provide a comprehensive psychosocial assessment upon admission to any service program. The purpose of the psychosocial assessment is to identify the individual's principal reasons for seeking services, to clarify needs and preferences, and to identify conditions that shall constitute the focus of the services provided. Persons serviced are informed of findings of assessment in language he or she can understand.

POLICY:

1) A comprehensive psychosocial assessment will be completed for all individuals served by ACR, regardless of the level of care or the type of program in which the individual is enrolled.
2) The results of the initial psychosocial assessment process will be used to assist in the development of the individual treatment plan for all persons served, and findings of the assessment are shared with the consumer, person served, legal guardian, and referral sources (with release of information) in a language he/she can understand.
3) Assessment results are additionally shared with clinical staff that are working with the consumer and family.
4) Assessments are conducted by qualified personnel who are knowledgeable to assess the specific needs of the person served and trained in the use of applicable tools, and are able to communicate with the person served.
5) The assessment includes information obtained from
    a) The person served
    b) Family members/legal guardians, when applicable or permitted
    c) Other collateral sources, when applicable or permitted; and/or
    d) External sources, when the need for specified assessments not able to be provided by the organization is identified.
6) When Collateral history is taken, information about the individual may not be shared with the person giving the collateral history, unless the individual has given specific written consent.
7) Initial assessments will be completed within the first three sessions, or first five days of treatment, depending on the program setting.
8) Assessments will contain, at a minimum, the following information:
    a) The individual's strengths, abilities, needs, preferences, attitudes, interests and skills.
    b) Presenting problems
    c) Urgent needs, including suicide risk, personal safety, and risk to others;
    d) Previous behavioral health history
    e) Physical health history and current status

f) Diagnosis(es)
g) Treatment history
h) Mental status to include current level of cognitive functioning, emotional functioning, and behavioral functioning
i) Current and historical life information including age, gender, sexual orientation, cultural background, spiritual beliefs, employment history, legal involvement, family history, history of abuse, neglect, violence, and relationships, including families, friends, community members, and other interested parties.
j) Co-occurring disabilities, disorder, or medical concerns.
k) Use of alcohol, tobacco, and/or other drugs
l) Need for, and availability of, social supports
m) Issues important to the person served
n) Need for assistive technology in the provision of services
o) Risk-taking behaviors
p) Level of functioning
q) Literacy level;
r) Advance directives, when applicable
s) Medication-use profile to include efficacy of current or previously used medication, as well as history and current use
t) Medication allergies or adverse reactions to medications
u) Psychological and social adjustments to disorders/disabilities
v) Resultant diagnosis(es), if identified.

9) When assessments result in diagnosis(es), the diagnosis is determined by a practitioner legally qualified to do so in accordance with all applicable laws and regulations.
10) Requests for previous diagnostic reports and relevant records will be made at the time of the initial assessment. All copies of previous records will be placed in the current individual record and will be integrated into the assessment process.
11) All assessments will be continually updated whenever a significant change occurs in an individual's treatment or program status, such as accomplishment of significant goals, as well as at reauthorization (every 6 months).
12) The initial and primary assessment shall result in an interpretive summary that serves the following purposes:
    a) Utilizes the assessment data to integrate and interpret the information in a manner that provides an emphasis on the interrelationships between the sets of findings, contains clinical judgments regarding both positive and negative factors likely to affect the person's course of treatment and clinical outcomes, and provides the central themes present throughout the information gathered.
    b) Is utilized in the development of the person-centered individual plan.
    c) Identifies any co-occurring disabilities/disorders that should be addressed in the development of the individual plan.
13) The assessment provides the basis for legally required notification when applicable.

14) All persons served who require additional assistance to complete the assessment process, due to disability or limitations, will be provided with the necessary support to do so within ACR's, capacity to accommodate the special needs.
15) Reassessments are performed or obtained by the provider if required to fully inform the services, supports, care and treatment provided. These may include but are not limited to:
    a) Assessment of trauma or abuse;
    b) Suicide risk assessment
    c) Functional assessment;
    d) Cognitive assessment;
    e) Behavioral assessments;
    f) Emotional assessment;
    g) Spiritual assessment;
    h) Assessment of independent living skills;
    i) Cultural assessment;
    j) Recreational assessment;
    k) Educational assessment;
    l) Vocational assessment;
    m) Nutritional assessment;
16) When necessary and identified during assessment process, consumers are referred for ongoing/reassessments based on individual need. These assessments may be conducted internally or externally and may include but are not limited to:
    a) Healthcare for:
    b) Routine assessment such as annual physical examination
    c) Chronic medical issues
    d) Ongoing psychiatric issues
    e) Acute and emergent needs
        i) Medical
        ii) Psychiatric
    f) Diagnostic testing such as psychological testing or labs
    g) Dental services

Policy 23.01 – Individual Recovery Plan (IRP)

I. POLICY:

A. It is the policy of ACR to assist all persons served in the development of an Individual Recovery Plan that serves as to guide all aspects of the individual's behavioral health care needs. The Individual Recovery Plan seeks to assist persons with maximizing their strengths and abilities, address their behavioral health goals through the identification of the care needs of the person served, document specific goals and objectives, outline the criteria for achieving specified interventions, and document individual progress in meeting specified goals and objectives.

II. PROCEDURES:

A. Individual Recovery Plans will be developed for all individuals served by ACR, within all levels of care, services, and/or programs in which the individual is enrolled.

B. Individual Recovery Plans will be developed based on the following guidelines:

a) The plan will utilize the information from the initial screening, referral materials, the psychosocial assessment, and the interpretive summary.

b) The plan will be based on the needs of the persons served and will focus on integration and inclusion into the local community, family, and natural support systems.

c) The individual's family and other significant relations will be involved in the plan's development, based on the appropriateness of the involvement and agreement by the person served.

d) The plan will identify both the needs that are beyond the scope of ACR's services and programs, and the specific services that will be provided by ACR.

e) The plan will be communicated to the person served in a manner that is understandable by ensuring that issues such as language and

comprehension level are taken into consideration when writing the plan.

f) Each person served will be provided a current Individual Recovery Plan.

C. The Individual Recovery Plan will be completed within 7 days of admission to ACR. Should the plan be completed at a later date than the specified time frame, documentation for such delay will be noted in the individual's record.

D. Individual Recovery Plans will be developed by the Intake Coordinator and Team Leader with the full input of all staff that are involved in the individual's service provision.

E. The Individual Recovery Plan will identify goals based on the individual's strengths, needs, abilities, and preferences. The goals will be developed within the following guidelines:

a) They will be expressed in the words of the person served.
b) They will reflect the informed choice of the person served.
c) They will be appropriate to the persons' culture and age.

F. The Individual Recovery Plan will contain the following components to support the individual's ability to achieve the identified goals:

a) Specific objectives that are to be met to provide a measurable indicator that the overall goal has been met. Specific objectives will be written to reflect an increase in functioning whenever possible, rather than a decrease of symptomology, to support a strengths-based model of services. Objectives will be reflective of the expectations of the person served and the service providers, the person's age, developmental factors, culture and ethnicity, and disabilities or concerns.

b) Interventions necessary to achieve the stated objective. Interventions may include individual staff generated services, based on clinical training and expertise, participation in specific program services in a group setting, and a variety of ancillary services available within the community.

c) Frequency of the interventions to provide the necessary service level to achieve the stated objective.

d) Duration of the interventions to provide a time specific measure of the individual's involvement.

e) Staff responsible for providing the interventions/services necessary to achieve the stated interventions.

G. Persons served shall be active participants in the development of his/her Individual Recovery Plan. Active participation will include the following:

a) The person served will meet with the designated staff responsible for coordination of services and other service providers, as appropriate, to establish the overall goals of services.

b) Expectations and the anticipated outcomes of both the person served and providers of services will also be discussed with the individual at the time of plan development.

c) Once the plan is completed and finalized by the service providers, the person served will endorse his/her knowledge of, and participation in developing the plan by reviewing and signing the document.

d) The person served will actively participate in, and agree to any changes in his/her Individual Recovery Plan.

H. All Individual Recovery Planning conferences will be documented in the record, with a progress note and identification of all persons participating in the conference.

I. Regular reviews of an individual's progress will occur every day for ACT consumers and for the CORE consumers the review will occur once a month. The reviews that are held will document completion of portions of the plan, significant events or changes in the life of the person served, and the delivery of services that support the Individual Recovery Plan.

J. Individual Recovery Plans will be updated whenever a significant change in clinical status, services, or programming requires such a revision, and/or by timelines established by the organization.

K. The person served will actively participate in, and agree to any changes in his/her treatment plan. All conferences in which changes in the Individual Recovery Plan are discussed and/or made will be documented in the record.

L. The Clinical Director will assume primary responsibility for implementing and monitoring the Individual Recovery Plan, coordinating the services indicated, coordinating and facilitating the reviews of progress, participating in team meetings in which program specific goals are reviewed, and orienting the individual to the services identified in the plan as agreed upon to meet the overall goals.

M. The designated staff member responsible for the individual's service coordination the staff responsible for specific objectives, the person served, and family members, if appropriate, will determine together when the Individual Recovery Plan goals have been met.

N. Should a person have a co-occurring disability, the Individual Recovery Plan will specifically address those issues in an integrated manner, and services will be provided by personnel, either within the organization or by referral, who are qualified to provide services for persons with co-occurring disabilities.

Policy 23.02 - Treatment Team

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) that individuals, advocates, family members and significant others as well as all professional staff providing services participate in the treatment planning and review process in a collaborative manner.

II. PROCEDURES:

A. ACR holds regular multidisciplinary treatment team meetings to develop individual treatment plans, review treatment progress, modify levels of care, authorize and coordinate services, and authorize individual discharges. The frequency of the meetings is dependent on program that individual is in and individual needs. The treatment team assesses appropriateness of treatment interventions relative to individual needs, accuracy of assessment, feedback from the individual and significant others. The treatment team will give priority to persons with multiple treatment episodes in the hospital and / or who have been assessed to pose a risk of harm to self or others. The group is reflective of the cultural diversity of the area population and individuals served.

B. The team encourages individuals served to actively participate with the team to promote recovery and maximum integration into the community.

C. In addition, Treatment Team meetings are run so as to provide training to enhance the clinical skills of direct services staff.

D. Treatment is a collaborative process between the individual, family, advocates, representatives of other service providers, and ACR staff. Upon entry into services the individual and assigned case manager collaborate to develop a viable treatment plan. Following the initial assessment visit, the case is staffed at the next multidisciplinary treatment team meeting, or no later than ten working days, to review the assessment and further develop the treatment plan. After the initial staffing the case will be reviewed at individual's request, when services are added or updated, at reauthorization, when a change in level of care is indicated, Assault Risk is indicated, and at discharge. Individuals, family, advocates, etc. are encouraged to participate in the development of the treatment plan and attend treatment team meetings on a regular basis. Individuals or advocates may request to attend treatment team meetings at any time during the course of services. It is the responsibility of the case manager to document inclusion of the individual within the treatment team process. The

treatment team and case manager inform the individual of the transition criteria that must be met to move to a new level of care and this is detailed in the transition plan of the Individualized treatment plan.

E. During the initial assessment the intake staff completes an Assault Risk Assessment. If significant risk factors are indicated the treatment team will review the assessment and appropriate safeguards set. A review date will be determined to review any restrictions on treatment that are set. The team is responsive to the changing needs of the person and will work with the individual to access assistive technology when needed.

F. Persons who are at risk for multiple hospitalizations or suicide should be reviewed by the Clinical Director with treatment team. They should also be reviewed by the agency psychiatrist where their history, discharge summary and suicide risk assessment can be reviewed to determine appropriate level of care recommendations, regardless of payor source. These recommendations will be noted in the persons' clinical record.

G. Treatment Team Notes documents the attendance of individuals and staff. The Treatment Team Note becomes a part of the individual file.

H. **Treatment Team Composition**: Clinical Director in coordination with Program Director/Team Leaders determines the persons who will participate in the individual's treatment and recovery. The individual and with individual permission their identified family member (treatment partner) will always a be member of the treatment team. A primary consideration in the selection of the staff who will be assigned to a individuals treatment team will be the preferences of the individual and their families. The credentials and expertise of the staff members assigned will also be reviewed for appropriateness to provide services to a specific individual. If it is determined by the Clinical Director that a individual's needs exceed that what can be provided by the agency's current staff consideration will be made to refer out for the needed services or contract with a provider to who can meet the client's needs.

Note: Appropriate Release of Information must be obtained before family members or treatment partners can participate in treatment team meetings.

Policy 24.01 – Transition/Discharge Procedures

PURPOSE: To ensure that all individuals are discharged from ACR in a systematic fashion.

POLICY:

A. In order to make all closing notes uniform throughout the program, the following format shall be used in all cases opened by the program and then closed. It is the policy of ACR to discharge individuals if the following has occurred:
    1) The individual no longer meets admission criteria.
    2) The goals of the individual's service plan have been substantially met and the individual requests discharge.
    3) The individual transferred to another service/level or care is warranted by changing individual's condition.
    4) The consumer required services are not available in this level of care.
    5) Adequate continuing care plan has been established.
B. A transition/discharge summary for each individual will be completed within 30 working days of termination and a copy will be provided to the individual.
C. Follow-up after discharge or referral to ensure that the individual has made successful linkage to the new program or service, and if not help the individual navigate any barriers.
D. Individual choice and preference will be respected throughout the transition/discharge process.

PROCEDURE:

A. This format is to be used for individuals who received services and they are registered on the program's caseload.
    1) Discharge Summary
    2) Individual's name
    3) Initial Diagnosis
    4) Services rendered
    5) Discharge date
    6) Reason for admission

Transition/Discharge Plans will include:

A. **The presenting problem**: individual's perception of needed service, referral source, results of testing, interviews, etc, that supported admitting diagnosis.
B. **Course of treatment:** Type of therapy, learned treatment, individual's attainment/non-attainment of treatment goals, individuals added towards treatment, family involvement, etc.

C. **Final formulation in prognosis:** At least why the individual is being discharged from services, listing of all referrals made by the program while individuals received services, individual satisfaction with the services rendered prognosis, etc.
D. **Condition at Discharge**: A statement on the individual's current status at discharge, including individual's strengths, needs, preferences and abilities of person served.
E. **Final diagnosis:** Self-explanatory
F. **Aftercare Plan:** All individuals being discharged from ACR will have after-care plan developed identifying the services/programs that the individual has agreed to participate in after leaving ACR services. ACR will identify in the Transition/Discharge Summary the resources appropriate for the individual once leaving ACR services. Transition/Discharge Summaries will include the referrals made to stabilization services, resources and/or step-down programs.
G. **Follow-up**: ACR will follow-up with individuals to ensure the they were able to successfully engage with the new provider. ACR will assist the individual by helping the individual overcome any barriers they may encounter in making the transition, to include communication with the new provider and providing support during gaps in care.
H. **Individuals in need of intensive services**: During the discharge planning process, ACR will identify any individuals who are at risk of hospitalization, harm to self or others. Once individuals who are high risk are identified, ACR will provide **warm-hand-off discharge** which will include a discharge planning meeting with the new provider. In addition, ACR may if warranted continue to provide limited services to the individual in coordination with the new provider when it is necessary to assist the individual in making a successful transition.

24.01.1 – Child and Adolescent
Transition and Discharge Planning

I. POLICY:

It is the policy of ACR to initiate the process of transition planning early in an individual's entry into programming. Transition planning will facilitate transfers to less intense levels of care within the organization or to community resources. Within this process, transition planning will fully involve the persons served, will be integrated within individual plans, and will result in a written transition plan when exiting a program. The persons served will be contacted after transition or discharge to gather information about their status to determine whether additional services are needed and to determine the effectiveness of its services. Discharge summaries will be placed in the consumers record within 30 days of discharge from ACR programs.

II. PROCEDURES:

A. ACR implements written procedures for;
   a. Referrals
   b. Transfers to another level of care, when applicable
   c. Transfer to other services
   d. Inactive status, if appropriate
   e. Discharge
   f. Follow-up
   g. Identifying:
      i. When transition planning will occur; and
      ii. Where the following are documented
         1. Transitional planning
         2. Discharge Summary

B. Stages of Transition/Discharge Planning:

1) Initial Assessment: Transition/discharge planning will occur within the initial psychosocial assessment upon entry into programming. Through the process of inquiring as to the individual's expectations of participation in programming and the discovery process of assessing an individual's overall goals and objectives, the initial formulation of what will constitute a successful program experience will be determined. Issues related to transition, such as probable length of stay, initial formulation of program goals related to program completion, and the development of needed community resources and supports, are generated through the initial assessment process.
   a. At any point during treatment, when specific needs are identified to

assist the consumer with increasing or maintaining optimal levels of functioning, and the delivery of such services are beyond the scope of ACR, referrals may be made. This includes, but is not limited to:

i. Alcohol and drug services
ii. Case management
iii. Community housing programs
iv. Inpatient services
v. Psychiatric services
vi. Nursing services
vii. Speech-language pathology

2) Person Centered Plan: Transition planning will occur as part of the individual plan through the development of goals and objectives related to successful program completion, and goals that are specifically related to assisting the individual's transition to another level of care or community aftercare supports.

3) Progress Reviews/Individual Plan Reformulation: Transition planning will occur within the progress review process through determining the status of the individual's achievement of program goals and objectives. Specific transition planning will occur through an analysis of length of stay and the further development goals specific to the actual transition process. If it has been determined that the consumer no longer requires services at the higher level of service delivery, the consumer along with the treatment team will determine the lowest level of care required to assist with maintaining the consumer in the least restrictive level of service.

4) Transition/Discharge Plan: A transition/Discharge plan will be developed and the onset of services, and reviewed/updated prior to an individual's exit from an ACR program. It will be developed through consultation with team members and direct input from the person served. It may also be developed with the input and participation of others, when appropriate, such as family members, legally authorized representative, referral source or other community services. The transition/Discharge plan will outline specific services to which the consumer will transfer. The original transition plan will be documented on all assessments and treatment plans, placed in the consumer's record, and a copy will be provided to the person served. Copies may also be provided to others who participated in the development of the plan, when permitted. Transition plans will be developed for all persons exiting any ACR programs. They will be developed for both persons entering other programming within the organization and persons exiting the organization. Further, transition or discharge summaries are provided to external programs/services, with appropriate releases, as necessary.

C. Components of a Transition/Discharge Plan

1) All transition and/or discharge plans will contain the following:

   a. Date of program admission.

   b. Date of program transition/discharge.

   c. Strengths.

   d. Needs.

   e. Abilities.

   f. Preferences.

   g. Name of program transitioning from.

   h. Name of program transitioning to (if applicable).

   i. Presenting condition at the date of entry.

   j. Current diagnosis.

   k. Describes services provided

   l. Progress in recovery or move toward well-being and current need for support systems for recovery maintenance and/or community reintegration.

   m. Gains achieved during program participation.

   n. Describes reasons for discharge;

   o. Consumer status at last contact;

   p. Referrals to assist in supporting continued maintenance or progress toward meeting personal goals and objectives.

   q. Information on options and resources available if symptoms recur or additional services are needed.

   r. Information about the continuity of the person served medication(s) prescribed or administered, if applicable.

   s. Recommendations to support and increase adjustment and well-being.

t. Referral source information, such as name and telephone number, if the person served is in need of assistance.

u. Living situation at discharge

v. Signatures of the staff member completing the plan and the person served.

D. Need for Additional Services or Aftercare Supports

1) When a transition plan indicates the need for additional services or supports, ACR personnel will assist in the transition in the following ways:

a. Assist with maintaining the continuity and coordination of needed services by providing follow-up contact with the person served and other programs, services, and community resources, should the person served permit such contact.

b. Determine through follow-up with the person served whether further services are needed.

c. Offer or refer the person served to needed services if it is determined through follow-up after transition that such services may be beneficial to the person's adjustment and well-being.

E. Unplanned Transitions and Inactive Status: ACR recognizes that from time to time, unplanned transitions occur as a result of unanticipated service modifications, reductions in staff, or exits precipitated by funding or other resource issues. In an effort to address this issue ACR will follow the below procedures:

1) If a person leaves a program or is placed in an inactive status for any reason other than a planned transition outlined in his/her individual plan, follow-up will be provided by ACR within 72 hours to:

a. Determine whether further services are needed.
b. Offer or refer the person served to needed services, when possible.
c. Provide necessary notifications
d. Clarify reasons for the unplanned discharge or Inactive status

2) Follow-up of unplanned transitions and inactive statuses will be documented in the individual's record.

E. Removal From Programming due to Assaultive or Aggressive Behavior

1) If a person served has to be discharged or removed from a program due to aggressive or assaultive behavior, follow-up will be provided by ACR to:

   a. Ensure that linkage has occurred to provide appropriate care.

   b. Ensure that the follow-up has occurred within 72 hours of the exit from the program.

2) Follow-up of persons discharged due to assaultive or aggressive behavior will be documented in the individual's record.

3) ACR outlines methods to reinstate restricted or lost privileges and rights on an individual basis, and documents such methods in the chart of the person served.

F. Case Coordination

1) When a person is transferred or discharged, ACR identifies:
   a. A process to ensure coordination; and
   b. The person responsible for coordinating the transfer or discharge.

Policy 24.02 - Continuum of Care/Transfer/Referral Process

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) that the provision of care in a continuous manner is essential to fulfill our organizational mission and philosophy. Our policy of continuity of care is intended to provide continuous and appropriate care over time and assure the provision of these services both internally and externally. The timely and orderly transfer to the appropriate services is necessary to our policy of continuing care for individuals.

II. PROCEDURES:

A. Intra-agency Continuity of Care

1. At the first point of contact with the individual, screening is initiated. The individual is referred to an external agency if the organization cannot meet the individual's request or need for service due to conflict with the organization's mission, philosophy capacity, or capability. If the individual is not referred externally and admitted for service, the Intake process and Biopsychosocial assessment process is initiated.
2. The assessor completes the Biopsychosocial assessment including admission to appropriate level of care. A psychiatric assessment, nursing assessment, and integrated summary are finalized along with the assignment of a Case Coordinator. The case coordinator is responsible for assuring the coordination of all services designated by the treatment plan.
3. If the individual and assessor determine the need for additional services within the same level of care, an additional goal and/or intervention is added to the Treatment Plan dated and initialed by the assessor. No further authorization is required.
4. If a individual moves to a different service site within the same Level of Care, then the Case Coordinator of the transferring site calls the Director of the receiving site to clarify the transfer. The transferring Case Coordinator schedules an appointment with the receiving site and assures that the individual is informed of this appointment. Documentation of the status of the individual and the reason for the transfer is completed. A documentation audit is completed.

5. If the individual and assessor determine that needs are better met in a more intense or less intense LOC (level of care), then the assessor assures admission to that LOC, completes MICP for authorization and prepares the record for transfer.
6. Individual contacts with After-Hours Emergency Services is reported to case coordinators the next working day. The contact is documented and faxed.

B. Inter-Agency Continuum of Care

1. Each individual needing adjunct services available in the community through another agency(ies) is referred to the appropriate provider(s).
2. Completion of the referral is documented in a Case Management Note.
3. Follow-up/monitoring will be determined by the case coordinator based on the significance of the external service to the Individualized Service Plan and the ability of the individual to follow through on his/her own initiative.
4. The individual is not transferred until the external provider agrees to accept the individual and the individual is sufficiently stabilized for transfer.
5. If referral to an external provider effectively ends services at ACR, the case coordinator maintains the individual's case until that referral is complete. Discharge from ACR is documented using the Transition Discharge Summary Form.

C. Referrals for Medical Care to Maintain Individual Wellness

1. As on normal part of the care provided to individuals referrals and linkages will made to ensure that all individuals receive the necessary medical to support and maintain wellness: These referrals include but are not limited to:
    a) Primary Care Physicians for physical health screens and care
    b) Specialty Providers as indicated
    c) Dentists
    d) Nutritionists
    e) Diagnostic Testing
        i. Psychological Testing
        ii. Laboratory Monitoring
2. The need for services outside of ACR will be identified through the assessment process or during the routine care provided by ACR staff to

include MDs, psychiatrists, nurses, case workers. The need for referral will be documented in case notes and provided to case manager who assist clients in making the necessary appointments.

3. Case Manager will monitor and follow-up within 2 weeks after the appointment to ensure the linkage was made with the external provider and work with individuals and their caregivers to resolve barriers that may interfere with individual receiving services from the external provider.
4. The case manager should document the referral and follow up attempts as a Case Management Services.
5. There may be times when the referral to an outside agency is considered to be an important part of the individual's treatment. In such cases, the case manager should include the referral in the individual's Individual Service Plan (ISP).
6. Follow-up services will continue as long as clinically indicated, or until there have been three documented unsuccessful attempts to contact the individual.
7. Case Manager will assist individual in completing any necessary forms for release of information to that ACR can share and receive information from external provider so that continuity of care is facilitated.

D. **Continuum of Care/Transfer/Referral Form** (ACR Form 24.02a):

1. Will be completed and forwarded by the ACR staff person recommending the internal or external services, supports or programs.
2. The ACR Form 24.02a will be signed by individual or guardian to indicate their agreement in being referred for external services and sharing information about the individual's needs with the external provider.
3. The ACR form 24.02a will be submitted to ACR case manager for processing.

Continuum of Care/Transfer/Referral Form (ACR Form 24.02a)

Policy 25.01 - Pharmacotherapy - General Guidelines

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to provide access to medications that support the maximum functioning of the persons served while reducing specific symptoms and minimizing the impact of side effects. To ensure this policy is fully realized, Assertive Community Recovery, LLC will enhance services through detailed and comprehensive Pharmacotherapy policy and procedures.

II. PROCEDURES:

A. Assertive Community Recovery, LLC will provide through direct provision or referral, access to medications and medication management to ensure that persons served are provided with maximum benefits of appropriate pharmacotherapy practices.

B. Assertive Community Recovery, LLC will ensure that all persons served receive optimal pharmacotherapy services. Services will include, but not be limited to:

1) All persons served will participate in initial and ongoing screenings and assessments of all areas related to medication use, including past medications use, its effectiveness, past side effects, and allergic or adverse reactions.

2) Screening and assessments will include the evaluation of co-existing medical conditions that may affect or be affected by the use of medications, and the identification of alcohol and other drug use, which may affect subsequent medication use.

3) Individual plans will reflect specific goals and objectives related to medications prescribed to support maximum functioning and minimize symptoms.

4) The organization will strictly comply with all applicable local, state, and federal laws pertaining to medications and controlled substances, including on-site pharmacy services and dispensing (if applicable).

5) A physician will be on call and available for consultation 24 hours a day, 7 days a week to support the persons served and staff members in all aspects of services related to medications.
6) All medications prescribed will be documented through the use of an informed consent form. The form will provide a guide for a comprehensive overview of each medication prescribed, its intended purpose, side effects, precautions, alternative treatments, approximate length of treatment, and risks. The form will also contain specific information in the area of precautions regarding the use of medications by women of child-bearing age, the use of medications during pregnancy, and special dietary needs and restrictions associated with use of the medications.

C. As per the Medical Emergencies Policy and Procedure, the telephone number of the local poison control center will be posted throughout the organization, and all staff members and persons served will be advised as to the location of this information.

D. If medications are prescribed by sources outside the organization, optimal outcomes will be supported through the following methods:

1) Staff members will request a release of information to communicate with the outside source, both verbally and through obtaining records, if appropriate.

2) If an appropriate release has been obtained, staff members will communicate with the prescribing source to clarify any information related to the medication regimen, will relate any information that may serve to maximize functioning for the person served through potential medication changes, and will provide information concerning individual functioning that may aid the prescribing source in decision-making.

3) Staff members will assist the persons served in arranging to meet with providers outside the organization who are providing medications and associated care.

E. All provision of medication management within the organization will be coordinated with the physician providing primary care through the following methods:

1) Staff members will request a release of information to communicate with the primary care provider regarding issues related to medications.

2) If an appropriate release has been obtained, the attending physician or designee, will communicate with the primary care physician or designee to discuss and/or clarify any information relevant to prescribing and taking medications.

3) A meeting or conference will be encouraged with the primary care physician, the organization's attending psychiatrist/physician, the person served, family members, and staff members involved in direct services of the person served if it is determined that such a meeting would facilitate communication between the parties that would be beneficial to the person served.

F. The organization will utilize medication treatment guidelines and protocols consistent with current practices in Pharmacotherapy. Attending physicians and other qualified professionals licensed to prescribe medications will maintain continuing education and training associated with licensure and certification requirements and maintenance of best practices in the field of Pharmacotherapy. All staff members involved in medication services will maintain performance objectives on a yearly basis associated with medication treatment guidelines and protocols.

G. Drug Utilization Review: The organization will maintain a program of drug utilization review to monitor drug usage and prescribing practices and assist providers with information to improve prescribing and dispensing practices.

1) The drug utilization review program will be chaired by a physician and made up of a representative group of health care professionals who have recognized knowledge and expertise in one or more of the following:

a. The clinically appropriate prescribing of psychotropic drugs.

b. The clinically appropriate dispensing and monitoring of psychotropic drugs.

c. Drug use review, evaluation, and interventions.

d. Medical quality assurance.

2) The drug utilization program will provide education to practitioners about common drug problems with the aim of improving prescribing and

dispensing practices, monitoring drug usage and prescribing practices, and educating providers of inappropriate drug utilization when it deems it appropriate to do so. The program will utilize two specific methods of review as follows:

a. Individual-Specific Review: This review will be conducted monthly. Prescription profiles will be selected for review based on individual risk for drug therapy problems. The process will include a risk assessment of all recipients and utilize therapeutic criteria covering multiple classes of medication. When appropriate, written feedback will be sent to a physician and/or pharmacist provider.

b. Problem-Focused Review: The emphasis of this review will be narrowed to a specific therapeutic issue where broad scale provider education may be valuable. Selection for review will be based on a specific diagnosis or medication. Topics of review will often be derived from issues identified during individual-focused reviews.

Policy 25.02 - Medication Disposal Procedures

I. POLICY:

It is the policy of Assertive Community Treatment, LLC (ACR) to dispose of all expired, discontinued or unused medications in a manner that ensures the medications are not used for any purposes other than that which they were intended, and to ensure adequate protection to personnel handling, disposing of sharps and biohazardous waste.

II. PROCEDURES:

A. Medication Disposal:

1) Expired or unused medication will not be used for administration.

2) Medication with incorrect labeling or count will be returned to the pharmacy of origin for correction.

3) Each medication's expiration date will be checked prior to each administration.

4) Any expired, unused or discontinued medication will be removed from the storage area, with the following information recorded in the Medication Disposal Log:

   a. Date discontinued or expired.

   b. Prescription number.

   c. Individual's name.

   d. Medication, strength, quantity.

   e. Disposal method.

f. Staff signature.

g. Witness signature.

5) The disposal of all medication will be witnessed by two staff members and documented in the Medication Disposal Log.

6) Medication Disposal Methods:
    a. FDA guidelines (www.fda.gov) for drug disposal will be followed which are summarized below
        1. Follow any specific disposal instructions on the drug label or patient information that accompanies the medication. Do not flush prescription drugs down the toilet unless this information specifically instructs you to do so.
        2. If no instructions are given, throw the drugs in the trash, but first:
            a. Take them out of their original containers and mix them with an undesirable substance, such as used coffee grounds or kitty litter. The medication will be less appealing to children and pets, and unrecognizable to people who may intentionally go through the trash.
            b. Put them in a sealable bag, empty can, or other container to prevent the medication from leaking or breaking out of a garbage bag.
    b. Before throwing out a medicine container, remove all identifying information on the prescription label to This will help protect consumer's identity and the privacy of their personal health information.
    c. When in doubt about proper disposal, talk to a local pharmacist.
    d. The same disposal methods for prescription drugs could apply to over-the-counter drugs as well.
    e. Large quantities will be placed in the incineration box for pick-up by the contract incinerator facility.
    f. Empty medication containers, used creams, ointments, etc., will be placed in the trash after any identifying labels are removed or made illegible.

Policy 25.03 - Medication Administration

I. POLICY:

It is the policy of Assertive Community Recovery (ACR) that the nursing staff will follow nursing standards of care in the management and administration of medications. It is recognized that some clients served by this agency will require assistance in the administration of oral medication prescribed by the agency's physician or physician extender; or will require the use of injectable medications in their therapeutic regimen. Every effort is made, however, to maintain clients on oral medications when this route of administration can achieve therapeutic benefit with adequate client compliance. When staff administers medications, it is done in accordance with all standards established by the Georgia Department of Behavioral Health and Developmental Disabilities (BHDD) and all laws of the State of Georgia.

II. PROCEDURES:

A. All medication administered for mental health/substance abuse clients by agency staff or supervised self-administered medication is prescribed or approved (if prescribed elsewhere) by an agency physician or physician extender.

B. All medication administered must be properly labeled with the client's name, medication, dosage and administration directions.

C. Physicians (MD's), Licensed Practical Nurses (LPN's), Registered Nurses (RN's), and Physician Assistants (PA's) are qualified to supervise self-administration by virtue of their licensure and medical training. Staff and contracted providers who have received the agency's training for the supervision of self-administered medication are also qualified to supervise self-administration. This training is documented on the training documentation form, and must be updated every 12 months. Copies of training record will be maintained in the staff personnel file and agency training record.

D. Physicians (MD's), Licensed Practical Nurses (LPN's), Registered Nurses (RN's), and Physician Assistants (PA's) are qualified to administer injectable medications and are authorized to do so only when order by a licensed physician.

E. All medications that are administered by ACR staff, all supervised self-administered medication, all medication errors and all adverse drug reactions are documented in the client record.

F. The **"Seven Rights"** for medication administration will be practiced at ACR:

1. **Right Person** (consumer must state name)

2. **Right Medication** (nursing staff must compare medication to physician order before administration)

3. **Right Time** (nursing staff must document time and adhere to same schedule)

4. **Right Dose** (nursing staff must verify on physician order)

5. **Right Route** (nursing staff must verify on physician order)

6. **Right Position** (nursing staff must verify on physician order)

7. **Right Documentation** (nursing staff must include: client name, medication name, medication dosage, date, time, nursing staff signature, title, and initials)

G. Any medication or topical treatment administered or supervised by staff is documented on the Medication Administration Record (MAR).

H. If the medication is refused or held, staff will document the reason the medications are not being given and alert the physician.

I. Adverse drug reactions and medication errors are reported per Adverse Drug Reactions, ACR Policy 25.13 and Medication Errors, ACR Policy 25.07.

J. When adverse drug reactions occur, staff and/or all persons who are responsible for administering or supervising self administration of drugs to the client are alerted.

K. All known medication/drug allergies are “flagged” or conspicuously noted on the cover of the client’s clinical record or the record will be labeled as “No Known Allergies or (NKA)”.

L. Up-to-date pharmaceutical reference materials are available to all direct care staff responsible for assessing medication effects. One source is www.drugs.com.

Policy 25.04 - Medication Inventory

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to maintain the security of all medications through an ongoing inventory of all prescription medication to verify that it is maintained appropriately and free from loss and/or misuse.

II. PROCEDURES:

A. Non-Controlled Medication:

1) All prescription medications are to be counted to verify quantity when services begin, when prescribed, or when new medications enter the facility.

2) The non-controlled medication will be documented in the Medication Inventory Log, after the initial count, at each location medication is stored. The following information will be documented in the log:

   a. Date of count.

   b. Individual's name.

   c. Name of medication, quantity, and strength.

   d. Prescription number.

   e. Staff signature/initials.

B. Controlled Medications:

1) All controlled medications are to be counted at each shift change and documented in the Controlled Substance Inventory Log. The count will be completed when the medication keys are exchanged by the staff

members who are changing shifts. Both staff members will conduct the count.

2) The Controlled Substance Inventory Log will contain the following information:

    a. Date and time of count.

    b. Individual's name.

    c. Quantity of medication at the beginning of shift.

    d. Amount dispensed.

    e. Quantity of medication at the end of the shift.

    f. Staff signatures/initials of both staff members.

3) Any discrepancy in the controlled substance count will be reported immediately to the supervisor. The supervisor, with the input from the staff members, will complete an incident report, as per the incident report policy and procedures, and will initiate an ongoing investigation to complement the incident reporting procedures.

4) The controlled medication procedures and inventory log will be randomly audited for accuracy and correct documentation by the Director of Nursing. Any discrepancies will warrant initiation of a Quality Assurance investigation.

C. Sample Medication:

1) Sample medication is medication given to a physician for client use by a licensed pharmaceutical company. It will be used only in cases when there are no alternative sources of medication available, and its use will be time-limited.

2) Sample medication will be prepared, pre-packed, sealed, and labeled prior to distribution.

3) Sample medication that is stored at the facility will be counted weekly and recorded in the Sample Medication Log.

4) When sample medication is used, the following will be recorded in the sample medication log:

    a. Date of use.

    b. Name of individual receiving medication.

    c. Quantity used and the amount remaining in stock.

5) Sample medication will only be used under the order and supervision of a physician.

Policy 25.05 - Medication Training and Education

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to ensure that appropriate education and ongoing training is provided to the persons served, family members, and service providers regarding the practice of prescribing and dispensing medications, the conditions for which medication use is indicated and the impact the medication may have on an individual's disability and/or quality of life.

II. PROCEDURES:

A. Medical staff will meet with all persons served and family members, when appropriate, prior to the initiation of any prescribed medications, to provide education regarding the medications that are chosen for use.

B. Through the use of informed consent, medical staff will provide the persons served and their family members with education in the following areas:

1) Biological principles associated with the medications.

2) The risks and side effects of each medication.

3) The intended benefits.

4) Contraindications associated with the medications.

5) Possible adverse interactions between multiple medications and food.

6) Risks associated with pregnancy.

7) The importance of taking the medications as they are prescribed.

8) Laboratory monitoring, if appropriate.

9) The rationale for the medications.

10) Alternatives to the use of medications.

11) Alternative medications.

12) Signs of relapse and/or non-adherence to medication prescriptions.

13) Potential drug reactions when combining prescription and non-prescription medications.

14) Instruction on self-administration, when applicable.

C. Persons served and their family members will receive ongoing education concerning their medication at a minimum of every 90 days during the Quarterly Medication Review process. As per the Medication Documentation Policy and Procedures, a Quarterly Medication Review will be completed every 90 days and will include the following information:

1) The person's name and ID/social security number.

2) Documentation of the need for continued use of medication.

3) Current medication prescribed.

4) Documentation of any unusual side effects and management strategies for control of side effects.

5) Documentation of any contraindications associated with the medication.

6) Documentation that all unusual side effects and contradictions have been discussed with the person served.

7) Observations related to continued medication use and the observed behavior of the person served.

8) Signature of physician, credentials, date, and printed name.

D. The quarterly review process will include a meeting with the person served and family members, if appropriate, to discuss all aspects of the medication regimen and continue the process of ongoing education regarding the prescribed medications.

E. Persons served shall be encouraged to seek information and education regarding their medication regimen or any additional aspects of medication treatment at any time in their participation in services.

F. Staff members who are directly involved the administration of medications and staff members who are involved in the direct service provision of persons using medications as part of their treatment, will receive ongoing education and training in pharmacology. The training will include all aspects of the use of medications, risks, benefits, side effects, contraindications, adverse interactions, risks, rationale for using medications, alternatives to medications, alternative medications, ways to recognize non-adherence to medication, potential drug reactions, and other relevant aspects of medications use. Education and training will be provided in the following formats:

    1) Regular, required in-service presentations by medical staff who possess expertise in these areas as part of their licensure and certifications.

    2) Regularly scheduled staff meetings conducted with ACR's psychiatrist.

    3) Reference materials are readily available to all providers, such as the Physician's Desk Reference, and educational materials directly related to the use of medications in a behavioral health setting. Reference material information will include information on generic and brand name drugs, strength and dosage, and pharmacological data, including contraindications and side effects.

G. Personnel files will reflect the ongoing training and education in the area of Pharmacology, and individual performance evaluations will contain specific goals and objectives in this area, if appropriate.

Policy 25.06 - Medication Documentation

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to document medication administration accurately and complete the necessary documentation to ensure all the requirements for the management of medications are fully met.

II. PROCEDURES:

A. Documentation Requirements:

1) Consent for Medication Form: All medications prescribed by a physician will require the completion of a Consent for Medication form. This form will contain the following information:

   a. The medication necessary for the overall treatment.

   b. The category of medication and the expected benefits.

   c. The specific medication name and dosage range.

   d. Purpose of the medication.

   e. Common side effects.

   f. Alternative treatments.

   g. Approximate length of treatment.

   h. Risks.

   i. Attending physician's signature.

   j. Person served or legal representative's signature.

2) Physician Order Form: This form will be completed at the onset of medication treatment, and completed by a physician or a nurse, acting on orders from the physician. The form will contain the following information:

    a. The person's name and ID/social security number.

    b. Acknowledgement of advice of side effects and consent.

    c. Date medication prescribed.

    d. Name of medication.

    e. Dosage.

    f. Strength.

    g. Route of administration.

    h. Schedule of administration.

    i. Dates discontinued or changed, with specific reasons for change.

    j. Next medication follow-up appointment.

    k. Signature of physician ordering or nurse, if acting on verbal orders.

    l. Signature of physician within two working days of order, if the nurse wrote the order.

3) Medication Administration Record (MAR) (ACR Form 25.06a): A Medication Administration Record form will be completed whenever a medication, as ordered or PRN, is administered. This form is initiated at the time the medication is ordered by the physician. The MAR will be changed monthly or as needed. The MAR is changed by transcribing the physician order to the MAR and can be completed by a nurse or employee trained in medication management. Each person served will have a Medication Administration Record Form which contains the following information:

a. The person's name and ID/social security number.

b. Date of administration.

c. Dosage, strength, route, frequency of administration, and number of supply given.

d. Signature of person receiving the medication.

e. Next medication due date.

f. Initial of nurse administering medication.

g. Signature of nurse administering medication, with credentials.

h. If PRN medication is given, additional documentation should be noted, including the complaint or reason that medication was needed, and an evaluation of the effectiveness or any side effects 30 minutes after the medication was taken.

4) Off Site Medication: If it is necessary for persons served to follow their medication regimen away from the organization's facilities, an Off-Site Medication Form will be used.

a. The following information will be documented prior to the person served leaving with medications on an overnight status:

1. The name of the person served.
2. To whom the care of the person served is being released and his/her relationship to the person served.
3. The address and telephone number of the person to whom care of the person served was released.
4. Medication name and strength.
5. Frequency and quantity.
6. The time, date, and staff initials noting the transfer of medication and to whom the medication was given.
7. Signature of the person receiving the medications.

b. Upon a return from overnight status, the following information will be documented:

1. The name of the medications returned, quantity returned, time, and date.
2. Staff initials, signature, and date.

c. For persons served who require medication and are going off-site but returning the same day, the following information will be documented.

1. The name of the person served.
2. Medication name, strength, and quantity.
3. The name of the person to whom medications were released, date, time, and staff initials.
4. Signature of person to whom medications were released.
5. The name of the medications returned, quantity returned, time, date, and staff initials.

5) Quarterly Medication Review: A Quarterly Medication Review will be completed every 90 days by the physician or qualified professional licensed to prescribe medications, and will address:

a. The person's name and ID/social security number.

b. Documentation of the need for continued use of medication and the efficacy of the medication.

c. Current medication prescribed.

d. Documentation of any unusual side effects and management strategies for control of side effects.

e. Documentation of any contraindications associated with the medication.

f. Documentation that all unusual side effects and contradictions have been discussed with the person served.

g. The appropriateness of the continued use of each medication, based upon the needs and preferences of the person served.

h. Signature of the physician, credentials, date, and printed name.

6) Progress Notes: Progress related to medication management will be noted in the record at the following times and in the following manner:

    a. Whenever a medication administration occurs, or whenever a physician prescribes a medication, documentation will include the date of service, reference to the treatment plan, and a brief statement summarizing the service.

    b. The Quarterly Medication Review will be documented in the progress note as per the required components described in this policy.

7) Allergy Sticker: Allergy stickers will be placed on the front of all records for any person served known to have a drug sensitivity, and will be reviewed and updated by staff, as appropriate.

B. Related Documentation Procedures:

1) Telephone medication orders are to be accepted by licensed nurses and documented on the Physician's Order Sheet.

2) Ambiguous Physician's Orders: Staff members will ensure the safe administration of medication by clarifying any ambiguous physician's orders in the following manner:

    a. Staff members will consult with the assigned supervisor when there is a question concerning a physician's order.

    b. The supervisor will consult with the prescribing physician for clarification and/or resolution of the ambiguous order.

    c. The prescribed medication will be held and not administered/delivered to the person served until the ambiguous order is resolved.

3) If a prescribed medication is not given for any reason, a corresponding progress note needs to be completed documenting the circumstances and reason the medication was not administered. If the lack of administration is deemed to be counterproductive to the welfare of the person served, the person in charge of administration is to inform the

physician and, if applicable, the person who is coordinating the care of the person served.

4) In the event of an allergic reaction or other side effect related to the prescribed medication, a staff member will notify the prescribing professional and document the event in a progress note.

5)
Attached Medication Administration Record (MAR) (ACR Form 25.06a)

Policy 25.07 - Medication Errors

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to address medication errors in a manner that significantly reduces and manages risk and results in improved services and outcomes.

II. PROCEDURES:

A. Medication errors will be defined as not following the established policies and procedures regarding Administration, Management, Disposal, Storage, and Inventory. Specifically the following key areas will define the parameters of medication errors:

1) Administration and Documentation:

a. Incorrect medication
b. Incorrect dose
c. Incorrect amount
d. Incorrect route of administration
e. Incorrect person
f. Incorrect time
g. Medication omitted
h. Incomplete consent form
i. Incomplete Physician order form
j. Incomplete Medication Administration Record documentation
k. Quarterly Medication Review not completed

2) Storage, Inventory, and Disposal:

a. Medication not stored in proper environment (refrigeration)
b. Medication not locked and maintained in a secure manner
c. Medication keys lost
d. Medication count not completed
e. Medication count results in extra or missing medication
f. Medication container mislabeled
g. Incineration containers not segregated and stored appropriately

h. Inappropriate disposal of syringes and needles

B. All medication errors will be reported in the following manner:

1) The Critical Incident policy and procedures will be utilized to report and fully investigate medication errors and result in organizational quality improvement activities.

2) The (supervisor in charge of medical services) will be immediately informed of the medication error and will notify the prescribing professional of any medication errors.

3) The individual receiving medication services will be informed at the discretion of the physician if it is determined through the physician's clinical judgment that the error impacted the treatment of the individual in any manner.

4) A progress note will be entered into the individual record when it is determined by the (supervisor and/or physician) that the medication error resulted in a significant degree of impact on the individual's care.

C. All medication errors that are not a direct threat to the individual's well-being will result in a verbal counseling contact between the employee and his/her supervisor. This contact will be documented and maintained in the employee's personnel file. Three such medication errors in a six-month period will result in verbal counseling a written corrective plan, and documentation in the employee's personnel file.

D. Medication errors that result in a direct threat to the health and safety to the individual being treated, can and may result in reassignment of the employee and, if necessary, termination of employment. These include, but are not limited to improper administration that results in injury or trauma to the individual.

E. Quality Improvement Program (QIP):
1) All medication errors will be reported as a Critical Incident as indicated in B.1 above
2) Once placed in the Critical Incidents Reporting System, medication errors will be reviewed by the ACR leadership team at a minimum once each quarter and monthly with the physician during the monthly Medical Quality Improvement Program review.

Policy 25.08 Medication Storage

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to store all medications in a safe and secure manner. Medications will be stored in the ACR Clinic Office, 4151 Memorial Drive, Suite 105-C, Decatur, GA 30032 under the control of Medical Director.

II. PROCEDURES:

A. All medication is to be stored in secure, designated areas under a double lock. Medications will be stored in cabinets and/or drawers that will be locked at all times when not in use. The cabinets and/or drawers will not contain items other than medication.

B. All prescription medications are to be stored in their original containers and have a legible label. All medications will be maintained in their original containers.

C. An individual's prescription and non-prescription medications, while maintained in their original containers, will be maintained in plastic zip-lock bags with the individual's name clearly marked on the bag. This will assist in organization of the medication storage area, and will also help with minimizing loss or misplacement of medications.

D. Over-the-counter medications are to be stored in the designated medication area. All over-the-counter medication is to be labeled with the individual's name and date of purchase.

E. Medications requiring special containers for stability are to be dispersed and stored in accordance with specifications.

F. All medications requiring refrigeration will be stored in a refrigerator in a secure area that is clearly labeled as "Medications Only." No other items, such as food or drink, will be allowed in the refrigerator. Refrigerated medications will be stored at 35-48 degrees Fahrenheit. Medications that do not require refrigeration will be stored at 59-86 degrees Fahrenheit.

G. Medications and pharmacy products will not be stored with food supplies, lab samples, or other non-pharmaceutical products.

H. Prescription pads used by physicians to order medications, medication supplies, and medication for incineration, are to be stored in safe and secure areas under double lock.

I. No employees may store personal medication at any facility and all medication storage areas will be maintained in a clean and orderly manner.

J. A designated staff member will retain the keys to the medication storage areas at all times. If at any time the designated staff member leaves the facility during a scheduled work shift, the keys to the medication storage area will be left with another qualified staff member at the facility. Any missing keys will be reported to the Medical Director immediately. If it is determined that the security of the medication area has been compromised, the locks will be changed.

Policy 25.09 - Laboratory Studies

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to ensure that Serum, Lithium, Tegretol, and Valporic Acid levels are drawn at least every 90 days for persons receiving Lithium, Tegretol, or Valporic Acid therapy, or as ordered by the treating physician or designee. All other necessary lab work will be completed at the discretion of the attending physician.

II. PROCEDURES:

1) The attending psychiatrist will order the lab work every 90 days or as needed for each person being treated with Lithium, Tegretol, or Valporic Acid, and will request other routine lab work as needed at his/her discretion.
2) Medical staff members will schedule persons served for designated serum levels to be drawn on a quarterly basis or as ordered by the physician.
3) Persons served will have blood samples drawn by a laboratory technician from a contracted laboratory facility.
4) The Lithium, Tegretol, or Valporic Acid levels will be drawn within 12 hours after the last dose. The medical staff members will instruct the person served not to take the morning dose of Lithium, Tegretol, or Valporic Acid on the day the blood sample is drawn.
5) The lab results will be reviewed by the assigned medical staff member(s) and be provided to the attending physician. The lab results will be filed in the lab section of the record.

Policy 25.10 - Tardive Dyskinesia Monitoring and Management - (Abnormal Involuntary Movement Scale) AIMS Reporting

I. POLICY:

It is the policy of Assertive Community Recovery, LLC to limit the use of antipsychotic medication for persons at high risk to develop the symptoms of Tardive Dyskinesia (TD), and to establish procedures consistent with early detection to minimize irreversible symptoms. Assertive Community Recovery, LLC will ensure that all persons receiving anti-psychotic medications are screened and monitored on a regular basis for symptoms of Tardive Dyskinesia.

II. PROCEDURES:

A. <u>Screening</u>:

1) All new admissions and readmissions to ACR's Core and Psychosis who are currently prescribed anti-psychotic medications will be screened for TD within 30 days of admission and twice yearly thereafter.

2) The Abnormal Involuntary Movement Scale (AIMS) will be used for the screenings.

3) Persons served who are prescribed anti-psychotic medication following admission to services will be screened with the AIMS prior to starting the medication, with screenings done twice a year thereafter.

4) All persons with a history of more than 90 days on anti-psychotic medications will be screened after the discontinuation of those medications at intervals of two, six, and twelve weeks. If the rating is negative at three months, screenings will be discontinued. If the rating is positive at three months, screenings will be continued every three months until the screening is negative.

5) All positive screenings that are determined to be probable TD will be referred to ACR Psychiatrist for confirmation and diagnosis.

6) The diagnosis must include one of the following:

    a. Probable.

    b. Masked Probable.

    c. Transient.

d. Withdrawal.

e. Persistent.

f. Masked Persistent.

B. <u>Management</u>:

1) All persons served who receive a diagnosis of TD will be informed of the diagnosis and re-evaluated in three months.

2) The AIMS evaluation, along with a progress note, will be entered in the record, and will be completed following each assessment.

3) Any persons served who are diagnosed with TD will be asked to sign an Anti-Psychotic Informed Consent Form in order to continue the medications, regardless of whether they have previously signed the form.

4) Any person served who receives a diagnosis of TD or enters services with this diagnosis, will be screened with the AIMS every three months, or more frequently, at the discretion of the psychiatrist.

5) Staff members designated to screen and monitor TD will be trained and certified in the AIMS examination and rating procedures with annual re-certification thereafter.

Attachments: AIMS Report

Policy 25.11 - Informed Consent for Medication

I. POLICY:

It is the policy of ACR that except in life threatening emergencies fully informed consent will be obtained before dispensing or administering any hypnotic/psychotropic medication to consumers. Procedures will meet or exceed the requirements of the Division of Human Resources.

II. Definitions:

A. **Psychotropic Medication**: Those medications that are categorized as antipsychotic, anti-manic, antidepressant, and anti-anxiety drugs. This does not include medications typically prescribed for extrapyramidal side effects.
B. **Initial prescription:** The first time a psychotropic medication is prescribed to a consumer or any subsequent change to the category of medication prescribed, but does not include changes of medication within the same category or changes in dosage.

III. Procedure:

A. The agency's physician shall examine the consumer and determine if psychotropic medication is indicated.
B. The agency's physician shall examine the consumer and determine if psychotropic medication is indicated. Said physician will document the required physician assessment in the records before the initial prescription.
C. At the time of the initial prescription, the physician will discuss with the consumer (and with the consumer's consent, significant family members, legal guardians, or care givers, if available) the indications for the medication prescribed, possible effects desired, possible adverse effects including but not limited to tardive dyskinesia, and potential interactions with other medications, diet and pregnancy, if applicable. Alternative treatment shall also be discussed.
D. The consumer will sign the Psychotropic Medication Informed Consent form, and the original will be placed in the consumer's chart. If available, the significant family member, legal guardian, or caregiver, will sign and date the form as a witness. This consent form will address the nature of the medication ordered,

the likely duration of the treatment with this medication, and possible effects of the medication as described under point 2 above. In addition, the consent form will record that the importance of complying with the medication regimen, and the need for initial and periodic medical and laboratory tests has been discussed. Finally, the consent form will record that the risks of not complying with the regime or not taking such tests as are ordered by the physician have been explained.

E. Whenever medication is administered emergently, procedures regarding consumer education and fully informed consent will be implemented to the extent practicable. The physician ordering medication administered will ensure that its effectiveness is documented in the chart.

Form 25.11a - Informed Consent for Medication

Policy 25.12 Medication Profile and Past Medication History

I. POLICY:

It is the policy of Assertive Community Recovery (ACR) that the clinical record provides documentation regarding the client's current medication profile and past medication history.

Information regarding the client's medication history and current use will be gathered and documented on the Client Medication Profile. This information will be obtained as part of the Initial Nursing, Comprehensive BioPsychoSocial Assessment or other assessments and updated whenever there is a medication change or at least annually.

II. PROCEDURES:

A. A clinician will assess all medications the client is currently prescribed or using. This information will include over the counter medications, vitamins and herbal preparations. The following information will be gathered and documented during the Medication Profile assessment:

1) Medication
2) Date Prescribed
3) Dose
4) Route
5) How Often?
6) Prescribing Physician
7) Prescribing Physician Phone Number
8) Reason for Taking Med
9) Date of Last Dose

B. A review of past medication use will be done and include the following information:

1) Effectiveness
2) Side effects
3) Allergies or Adverse Actions

C. Upon completion of the form, it is to be printed and filed in the clinical record.

D. Every effort will be made to coordinate care when a medication is prescribed by a source other than ACR and with the physician or health care professional providing primary care needs.

E. Information regarding medication use will be updated whenever there is a change or at least annually.

F. Nurses will review medication with clients during routine nursing assessments and on-going care visits to determine if any change in mediations need to documented on medication log.

Form 25.12a - ACR Medication Log

Policy 25.13 - Adverse Drug Reactions

I. POLICY:

It is the policy of Assertive Community Recovery (ACR) that all medical emergencies will be handled by qualified and appropriately trained personnel.

II. PROCEDURES:

A. When a medical emergency occurs at any site, immediate first aid and/or CPR, as appropriate, shall be administered by trained staff. Simultaneously, any available medical personnel shall be called to the site. The medical personnel shall provide emergency care as needed.

B. The Emergency Medical Service shall be called immediately at 911. Emergency care shall continue to be provided until the EMS arrives.

C. Adverse medication reactions, as a rule, are not of such a nature as to create a life threatening condition. Nevertheless, distress to the consumer may exist, and an assessment by nurse or physician will be carried out. Treatment intervention, according to the best standards of care, will be carried out under supervision of the agency physician. Further monitoring of the consumer by medical staff as indicated will follow until the reaction has resolved and any danger has passed.

D. Adverse Medication Reaction: The reporting of adverse drug reactions (ADR) is a voluntary Federal Drug Administration program for reporting serious drug reaction which results in patient hospitalization, death, cancer or congenital anomaly.

E. Upon identification of an ADR, the nurse or physician should notify the Medical Director with the patient's name, clinic location and the name, date and lot # of the medication.

F. The nurse or physician must document the following in the patient's medical record: a description of the reaction, any treatment, the outcome and patient education. A critical incident will submitted as indicated in ACR policy on Critical Incident Reporting.

G. The Medical Director will complete the FDA Report form, if appropriate, and notify the FDA.

- FDA Medwatch: 1-800-FDA-1088
- FDA Fax : 1-800-FDA-0178

- FDA Modem: 1-800-FDA 7737

H. Adverse Drug Reactions submitted through ACR Critical Incident Reporting System will be reviewed monthly in the Medical QIP Review to identify trends and report findings to the Medical Staff and QIP for further action.

I. QIP Manager will keep completed ADR reports and findings in a confidential QIP file.

Policy 25.14 - Supervision and Protocol for Consumer Self- Administration of Medications

I. POLICY:

It is the policy of to It is the responsibility of Assertive Community Recovery, LLC employees to provide instruction and supervision to consumers to self-administer their medication so that there will be safe and effective management of consumers taking their own medication.

II. PROCEDURES:

A. At ACR, only physicians and nurses are authorized the supervision self-administering of medications such as insulin, inhalers and/or suppositories by consumers.

B. A separate Medication Administration Record of all prescribed and over-the-counter medications must be maintained for each consumer self-administering their own medication.

C. Once medication(s) have been received from the pharmacist, information from the accompanying forms must be recorded (transcribed) in the Medical Administration Record.

D. Check that you have:

1. The medication in the container supplied by the pharmacist.
2. A correct and legible label on the container.
3. Written physician's instructions.

E. Check whether the consumer is functioning as independently as possible in the self administration process. We should always encourage consumers to take as much responsibility for their own medication administration as possible keeping in mind that our primary concern is the proper self-administration of medications by the consumer. If the consumer is having difficulty with self administering his/her medication, contact your supervisor.

F. **Abbreviations and Symbols:** Abbreviations and symbols are shortened forms of terms used to facilitate:

1. the interpretation of the physician's order/prescription/pharmacy label and,

2. the documentation of medications. They are primarily derived from Latin terms. Some of the common abbreviations and symbols are as follows:

    - Q or q Every or each
    - STAT At once (now)
    - D Day
    - (o) Orally
    - hr Hour
    - MOM Milk of Magnesia
    - q3h Every Three Hours
    - T tsp. Teaspoon
    - b.i.d Twice a day
    - T tbsp. Tablespoon
    - t.i.d. Three times a day
    - Gr Grains
    - q.i.d. Four times a day
    - mg Milligrams
    - h.s. (HS) Hour of Sleep
    - p.r.n. When necessary or as needed
    - Gm Grams
    - cc Cubic Centimeters
    - A.M. Morning
    - ml Milliliter
    - pm Afternoon
    - x Times
    - Oz Ounce

    NOTE: The periods shown above may not be included in the abbreviation/symbol. If you are unable to read an abbreviation or symbol, do not guess. Consult with the supervisor/physician/pharmacist for assistance in clarification and record your call in the consumer's medication record.

G. Eight Rights of Supervising Self-Administration

Each time an employee supervises a consumer's self-administration of medication, be sure to have the:

1. Right recipient (consumer)
2. Right medication
3. Right dosage
4. Right time
5. Right route

6. Right position
7. Right documentation
8.

H. **The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right**:

1. **Right Person:** includes the use of at least two identifiers and verification of the physician's medication order with the label on the prescription drug container and the MAR entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. In order to make sure it is the right recipient, staff have to know the recipient. Procedures listed in ACR Policy 22.04, Accurate Identification of Individuals Served will be followed. Procedures listed in ACR Policy 22.04, Accurate Identification of Individuals Served will be followed.
2. **Right Medication**: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin must be verified with another person prior to administering.
3. **Right Time:**
    a) When a physician prescribes a medication, he or she will specify how often the medication is to be taken. Be sure the consumer self-administers the medication as scheduled.
    b) Some medications must be self-administered only at very specific times of the day; for instance, before meals, or one hour after meals, or at bedtime, etc. It is very important that medication be self-administered as prescribed.
    c) Some medications may be prescribed by the physician on a Standing Medical Order which will be a part of the consumer's record on site. Medications for headache, constipation, and upset stomach are some examples that may fall into this category. There should be specific written instructions from the physician regarding when and under what conditions the medication should be self administered. Complete a medication log form and note the specified order on the form
4. **Right Dose**: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record entry to ensure that

all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken. Be sure that the consumer self-administers the right dosage by observing that he/she carefully measures or counts the correct dosage and that this amount agrees with the pharmacy label.

5. **Right Route**: includes the method of administration;
    a) The pharmacy label should state the route (channel) by which the drug should be self-administered if other than oral. For instance, it might state to externally apply an ointment to a rash. Supervise the consumer to follow the route directions carefully.
    b) If there is any doubt as to whether the medication is in the correct form as ordered, or can be self administered as specified, consult with the supervisor before supervising the consumer to self-administer the medication.
6. **Right Position**: includes the correct anatomical position; individual should be assisted to assume the correct position for the medication method or route to ensure its proper effect, instillation, and retention. Attention needs to be given to medication instructions to determine if there are special requirements regarding the consumer's position while self administering medications. In order to achieve medication effectiveness while also ensuring consumer's safety, some medications require the consumer to be in a particular position (ex. standing, sitting upright, lying down) while administering medication.
7. **Right Documentation:** includes proper methods of the recording on the MAR:
    a) Documentation must adhere to agency standards and include, but not limited to:
    b) Documentation of the medication given should be done as soon as possible after the medication is given.
    c) Chart site of injections and any complaints made by the client at the time of administration
    d) Chart the following:
        (1) Medication given
        (2) The dosage given
        (3) The time the medication was actually given

(4) Client's response to medication

(5) Any complaints or adverse effects experienced by the client related to the medication

(6) Never record the medication as given prior to administration

and

8. **Right to Refuse Medications:** includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.

I. When NOT to Allow Medication to be Self-Administered

There may be occasions when it is the scheduled time to have consumer self-administer medications, but usual circumstances require that staff do NOT proceed.

1. If any one or more of the following required items are missing: If the medication log form for the medication as per prescription number or a legible pharmacy label is missing **STOP!** Contact your supervisor or after hours Emergency Services for assistance/direction.
2. Consumer exhibits a dramatic change in status.
3. If the consumer is showing signs of seizures, unconsciousness, difficulty breathing, or other change that appears to be health threatening, do not give the medication. Follow the instructions given for reporting an emergency or life-threatening situation
4. If there is any doubt that it is the right consumer, right drug, right dosage, right time, or right route, get assistance from your supervisor.
5. Consumer refuses to take medication. Explain to the consumer why it is important to take the medication as prescribed by the physician and encourage the consumer to cooperate. If the consumer still refuses notify your supervisor.

J. Medication Supervision Guidelines

1. Observe the eight rights:
2. Right consumer, Right time, Right route, Right dosage, Right medication, Right position, Right documentation and Right to Refuse Medications.
3. Work with adequate light.
4. While preparing to supervise medications, concentrate on that alone.
5. Be knowledgeable about the medications: a). Why and how it is to be taken, b) Proper dosage, frequency, and duration, c) Possible side effects and adverse reactions, etc.

6. See that consumer take medications as prescribed and on time (1/2 hour before or 1/2 hour after scheduled time is considered "on time").
7. Known drug allergies will be noted in consumer's record file with red "allergic" label.
8. If there is anything unusual about the appearance or smell of the medication, do not allow consumer to take it until checking with the pharmacist or physician. If the medication must be withheld, your supervisor must be notified.
9. Have the prescription refilled while some medication remains.
10. If a discrepancy between the medication log and the pharmacy label is found, consult with the supervisor for clarification.

K. NEVER do or allow the consumer to:

1. Take any medication that has not been properly authorized.
2. Use a medication ordered for another consumer
3. Take a medication from another person's prescription bottle.
4. Pour medication from one bottle to another or re-label a bottle.
5. Mix medications together unless directed to do so by the prescribing physician.
6. Return an unused dose of medication to the bottle.
7. Cut an non-scored tablet.
8. Leave medication cabinets unlocked or medications unattended.
9. Refer to medications as "candy".

L. General Procedure for Preparing Medication

1. Check each consumer's medication log to see if any medications are scheduled to be taken during each shift.
2. Select medication log according to time and day medications are to be given.
3. Compare label of the medication container with the medication record three (3) times to ensure accuracy as follows:
4. Before the medications is taken from storage areas and given to consumer.
5. Before the consumer removes the medication from the container.
6. Before the container is returned to the storage area.
    a) Remind consumer of special instructions written on label or attached to container, i.e. shake, do not take with milk, etc.

b) Observe consumer taking capsules, tablets, or pills, etc.

c) Observe consumer measuring liquid medication in measuring spoons or measuring glass/cup.

7. Supervise one consumer's preparation for self-administration of medication at a time.

M. General Procedure for Supervising Self-Administration Medication

1. Positively identify consumer prior to administration of medication.
2. Ask the consumer his/her name.
3. If consumer is non-verbal, ask a third party to verify consumer's identity.
4. Explain to the consumer why the physician ordered the medication and the procedure.
5. Do not "force" a consumer to take medication against his/her will. (If refusal to take medication is a problem, consult your supervisor.)
6. Observe consumer taking his/her medication.
7. Provide adequate water to aid in swallowing tablets, capsules, etc.
8. If a consumer has difficulty swallowing tablets, capsules, etc., notify your supervisor. (Many medications are available in liquid form and the physician may choose to change the medication order.)
9. Remain with the consumer until he/she swallows the medication.
10. NOTE: Some medication is not to be swallowed, i.e., troches, lozenges, nitroglycerin.
11. Document that you supervised the consumer's self-administering the medication on the medication log form used for that medication by matching container label with form prescription number or medication name. Observe, record, and report any adverse response to the medication.

N. Additional requirements for Supervision of Topical Medications

1. In addition to the General procedure for medication described above observe the following special instructions.
2. Provide privacy if appropriate and requested. Instruct consumer to remove medication from jars with tongue blade or cotton tipped applicator. DO NOT USE FINGERS.
3. Instruct consumer to insert applicator or tongue blade into container only once, NEVER REINSERT.
4. Instruct consumer to use cotton tipped applicators or sterile gauze to apply topical medications unless otherwise directed.

5. Have the consumer wash his/her hands following self application.

Policy 25.15 - Authorization of Verbal and Telephone Orders

I. POLICY:

It is the policy of Assertive Community recovery, LLC (ACR) that all verbal orders be documented in the clinical record and cosigned and dated the same day or the following working day by the ordering physician or physician extender but not later than 72 hours after the order is received.

II. PROCEDURES:

A. Verbal/telephone orders are to be taken only by a licensed nurse, physician's assistant, or pharmacist. Orders may also be faxed by the ordering practitioner. These orders must be dated, timed, and signed by the ordering practitioner or designee.

B. When verbal orders are received from physicians, those orders will be authenticated by taking the following steps:

- Immediately by a fax of the order with the physician signature on the page;
- The fax must be included in the individual's record;

and

- By original physician signature within 72 hours after the order is received.

C. The medication, dosage, route, frequency and quantity dispensed will be documented on the physician/LIP order sheet to include the date and time the order was received, the ordering practitioner's name and the person accepting the order.

D. Each time a medication is administered, staff will document in the clinical record in accordance with Policy 5.01 Pharmacotherapy - General Guidelines, Policy 5.06 Medication Documentation and Policy 5.21 Medication Administration.

Policy 25.16 - Pharmaceutical Samples

I. POLICY:

It is the policy of Assertive Community Recovery (ACR) to accept and utilize sample medication as a temporary support to clients in need of the specific medications who have no other means of obtaining the medication.

II. PROCEDURES:

A. All sample medication must be stored in the locked sample cabinet/closet. At no time will samples be stored in individual offices or desks.

B. All samples will be inventoried and rotated monthly.

C. When samples are received and signed for, they must immediately be stored in the sample closet.

D. Samples should be used only as a temporary means of providing medications. The individual served must apply through the specific pharmaceutical company for a continued supply of the medication ordered/prescribed.

E. Physicians and Registered Nurses are the only staff who have authorized access to the sample closet.

F. Samples given will be documented in the client's record on the prescription form with the words "Sample Give" added to each line and signed out by authorized staff on the Sample Medications Inventory (ACR Form ###).

G. Packaged medication bottles/cards must be dispensed in the original pre-packaged condition. At no time will bottles/cards be opened or altered. The package should be labeled with the client's name and directions for administration.

H. Any expired medications will be removed from the inventory and destroyed.

I. In accordance with FDA regulations, pharmacy staff will not be allowed to monitor, distribute, inventory or handle any samples.

J. Medication Sample Inventory Records will be kept on file for a period of one year.

Policy 25.17 - Client Vital Signs

I. POLICY:

It is the policy of Assertive Community Recovery (ACR) to assess and monitor the client's physical health condition by assessing vital signs at regular intervals.

II. PROCEDURES:

A. Vital signs (temperature, pulse, respiration, blood pressure, weight) are taken according to the physician orders or as follows:

B. In the absence of specific orders, vital signs are to be taken for routine mental health services upon arrival, routine nursing assessments, or whenever clinically indicated.

C. Vital signs are to be assessed whenever clinically indicated at the discretion of nursing staff. If at any time vital signs are unstable, the nurse will notify the physician.

Policy 25.18 - Educating Individuals in the Use of Medication Organizers

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to provide instruction to Individuals in community settings on the proper usage of medication organizations that are capable with the Individual level of functioning and the support system in their natural environment.

II. DEFINITION AND BACKGROUND:

Medication Compliance: Medication compliance means taking medications as prescribed. Although medications have improved the overall quality of life for people with bipolar disorder, many people resist taking a variety of medications several times a day. People find the medication schedules confusing; they forget what they have taken; people start feeling better and stop taking the medication; or they do not feel that they can afford medications

A common problem with medication is that the person does not clearly understand what the medication will do for them. The person needs to understand what the medication is and why it is important to take it. "Because the doctor says so" is not enough of an explanation.

II. PROCEDURES:

A. Staff will educate Individuals and their caregivers on techniques to increase and maintain compliance with the Individual's medication regime. To encourage medication compliance explain why the medication is necessary (people are more apt to do what is requested of them when they are given the reason for the request).

B. Staff will educate Individuals o the benefits of taking medications as prescribed and the risks if medications are not taken.

C. To ensure the safety of Individuals in the medication administration and maintaining compliance the following as been identified as critical:

    1. Clear communication between the interdisciplinary team (Individual, caregiver, provider/prescriber, pharmacist, registered nurse, licensed practical nurse) is essential.

    2. Needs and safety of the Individual, along with the rights of the Individual to live as independently as desired, must be central to all care delivered.

3. Care given should be based on the best evidence for optimal health care outcomes.
4. Medication delivery and administration must be based on the "seven rights".
5. Medications must always be labeled and identifiable.
6. Policies must be consistent in community based care setting in which a Individual might live.
7. The process for providing the right medications to Individuals safely is not the exclusive province of any single agency or profession.
8. Assessment of Individual needs must be ongoing and collaborative: physicians, nurses, pharmacists, social workers and facility owner/operators must be involved with assessment and re-assessment, as well as interdisciplinary communication.

D. Many Individuals and caregivers may find it convenient to have the pharmacy place medications in blister packs with dosages organized by day.

E. No matter system or techniques used, nurses will evaluate the Individual, caregiver and their support environment to assist the Individual and caregiver in identifying the medication system that best supports the Individual in their community setting; and shall provide education/training to ensure that medications are taken in according to the prescriber instructions. Before educating Individuals on the use medication organizers, nurses need to evaluate such things as Individual:

1. Cognitive functioning
2. Physical limitations
3. Environment
4. Safety and security of medication storage
5. Organizational Skills
6. Support available from others
7. Desires

F. Only physicians or the Individual themselves may fill their individual customized medication packages ("Medisets", medication organizers, etc.) RN's/LPN's are limited to providing the Individual education on the use of "dayminders" and only after the Individual has been evaluated and determined to be capable of filling of his or her medication organizer.

G. At anytime that staff finds that the use of medication organizers is increasing or contributing to Individual non-compliance with medications or medication errors, nurses will be contacted to meet with Individual/caregiver to determine

steps needed to increase compliance with the medication regime. Note: Incident reports need to completed in accordance with policy.

Policy 25.19 -"Do Not Use" List of Abbreviations

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) that only approved abbreviations should be used in medical orders and medical related documentation so that there will not be any misunderstandings or confusion arising from the use of abbreviations, acronyms, symbols, and dose designations that should not to be used.

II. The Joint Commission Official "Do Not Use" List:

1. Medical staff will be familiar with the most recent Joint Commission Official "Do Not Use" List attached to this document and available online at www.jointcommission.org/PatientSafety/DoNotUseList.

2. Abbreviations, Acronyms and Symbols appearing on the **"Do Not Use"** List will not be used on any orders and medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

3. Whenever there are conflicts between ACR's Official List of Abbreviations, Policy 27.02 and The Joint Commission Official "Do Not Use" List; the **Joint Commission Official "Do Not Use" List will take precedence.**

Policy 25.20 - Medication and Trace Contaminated Waste Disposal

I. POLICY:

It is the policy of Assertive Community Treatment, LLC (ACR) to dispose of all expired, discontinued or unused medications in a manner that ensures the medications are not used for any purposes other than that which they were intended, and to ensure adequate protection to personnel handling trace contaminated antineoplastic waste.

II. PROCEDURES:

A. Medication Disposal:

1) Expired or unused medication will not be used for administration.

2) Medication with incorrect labeling or count will be returned to the pharmacy of origin for correction.

3) Each medication's expiration date will be checked prior to each administration.

4) Any expired, unused or discontinued medication will be removed from the storage area, with the following information recorded in the Medication Disposal Log:

   a. Date discontinued or expired.

   b. Prescription number.

   c. Individual's name.

   d. Medication, strength, quantity.

   e. Disposal method.

   f. Staff signature.

   g. Witness signature.

5) The disposal of all medication will be witnessed by two staff members and documented in the Medication Disposal Log.

6) Medication Disposal Methods:
    a. FDA guidelines (www.fda.gov) for drug disposal will be followed which are summarized below
        1. Follow any specific disposal instructions on the drug label or patient information that accompanies the medication. Do not flush prescription drugs down the toilet unless this information specifically instructs you to do so.
        2. If no instructions are given, throw the drugs in the trash, but first:
            a. Take them out of their original containers and mix them with an undesirable substance, such as used coffee grounds or kitty litter. The medication will be less appealing to children and pets, and unrecognizable to people who may intentionally go through the trash.
            b. Put them in a sealable bag, empty can, or other container to prevent the medication from leaking or breaking out of a garbage bag.
    b. Before throwing out a medicine container, remove all identifying information on the prescription label to This will help protect consumer's identity and the privacy of their personal health information.
    c. When in doubt about proper disposal, talk to a local pharmacist.
    d. The same disposal methods for prescription drugs could apply to over-the-counter drugs as well.
    e. Large quantities will be placed in the incineration box for pick-up by the contract incinerator facility.
    f. Empty medication containers, used creams, ointments, etc., will be placed in the trash after any identifying labels are removed or made illegible.

B. Trace Contaminated Waste Disposal:

1) Trace contaminated waste will be contained and segregated from all other waste and placed in waste containers identified with the label "Antineoplastic Waste for Incineration."

2) Incineration waste containers will be kept in a designated locked cabinet and collected for disposal by the contract incinerator vendor.

3) Disposal syringes and needles will be placed into small biohazard puncture-resistant waste containers located in secure areas in or near the location used.

4) Small bio-hazard waste containers will be used in the following manner:

   a. Assemble the container.

   b. Place container in the medication preparation/administration area.

   c. Replace bags daily or more frequently, if necessary.

   d. Deposit waste material and gloves in the bag.

   e. Do not clip needles or detach from the syringe.

   f. Ensure that the needle cover is secure.

   g. Use a twist tie to seal the contamination bag.

   h. Place contaminated bag in the identified "Waste for Incineration" container kept in the designated location.

Policy 25.21- - Telemedicine Policy

I. POLICY:

A. It is the policy of ACR Health Care to adherence to all applicable laws, rules, and regulations while ensuring the individual served access to psychiatric/pharmacological management services through the use of "live two-way audio-visual communication". By implementing these procedures, ACR Health Care will provide "long distance" psychiatric/pharmacological management services to Individual served s.

II. PROCEDURES:

A. DEFINITIONS:

1) Pharmacological Management – A service provided to a Individual served by a physician, in accordance with TIMA to determine symptom remission and the medication regimen needed.
2) Psychiatric Evaluation – Psychiatric diagnostic interview examination by MD, Licensed Psychologist, APN, or PA.
3) Telemedicine – The use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. This definition includes: (1) live interactive two-way audio-video communication; and (2) any communication modalities such as phone, fax, e-mail, the internet, and still imaging that are used in conjunction with such live two-way audio-video communication. The same standards of care and protocol exist with telemedicine as are used when assessing and treating the Individual served on-site. The physician-Individual served relationship is the same.

B. APPLICATIONS/SCOPE

1) Services

a. The following services will be available through the use of telemedicine:
   1. Pharmacological management
   2. Psychiatric evaluation and diagnosis.
b. Treatment via telemedicine will not deviate from standards of care applicable to face-to-face assessment and treatment.
c. The telemedicine psychiatric service by the psychiatrist may be an adjunct to periodic face-to-face contact or it may be the only contact by the psychiatrist.

2) Locations

a. Telemedicine psychiatric services will be provided as follows:
   1. 1Individual served at remote location/Psychiatrist on site – Psychiatrist will be at the ACR Health Service's office and the individual served will be at a remote location.

2. Psychiatrist at remote location/individual served on site – Psychiatrist will be at remote site and Individual served will be at ACR Health Service's office.

3) Clinical Oversight: Clinical oversight of the telemedicine psychiatric services will be provided by ACR Health Service Medical Director.

4) Contraindications for Use: The consulting physician should request face-to-face consultation if the Individual served 's condition does not lend itself to a telemedicine consultation or if visual or sound quality is inadequate.

C. PROVIDERS

1) Telemedicine psychiatric services will be provided by licensed and credentialed psychiatrists who are full/part time employees or have a current contract with ACR Health Service. The clinical care will be provided within the scope of their licenses.

2) Other providers who may be present during the telemedicine psychiatric service include ACR Health Service nurses and case managers. The nurses will provide incidental services to the psychiatrist. The case manager will provide monitoring and support services to the Individual served .

D. PRIVACY, CONFIDENTIALITY AND SECURITY

1) The privacy and confidentiality of the telemedicine psychiatric service will be maintained by ensuring that the locations of the Individual served and psychiatrist are secure. The services will be provided in a controlled environment (closed doors) where there is a reasonable expectation of absence from intrusion by individuals not involved in the Individual served 's direct care.
2) "Do Not Enter" signs will be posted on the outside door of offices used in order to notify individuals not to enter the room during a psychiatric service.
3) ACR Health Service staff involved in the individual served care, family members and technical staff may at times be present in interviews. Individuals served will be informed about others present in the room at the distant site if such persons are off camera and appropriate authorizations for disclosure of information will be obtained. Whenever possible, the presence of non-clinical staff during a psychiatric service will be avoided.
4) If appropriate, an ACR Health Service staff member will be at the site with individual served during the telemedicine psychiatric service to ensure the safety of the Individual served.
5) The telemedicine psychiatric services will not be audio- or video-taped without written informed consent from the individual served .

E. INFORMED CONSENT

1) Informed consent for telemedicine psychiatric services will be obtained in writing from the Individual served prior to the service.
2) The Individual served will be made aware of the potential risks and consequences as well as the likely benefits of the telemedicine psychiatric services, and will be

given the option of not participating. Individual served s will be informed that services will not be withheld if the telemedicine psychiatric encounter is refused, although such care will depend on availability of alternative resources.

3) The content of the consent will be discussed fully and a note documented in the record that this has occurred.
4) The original signed consent will be filed in the Individual served medical record.

F. REQUIRED DOCUMENTATION

1) All documentation of telemedicine psychiatric services will be documented in accordance with applicable standards, guidelines, by-laws, rules and regulations.
2) A Progress Note will be written by the psychiatrist to document each visit with the Individual served . The progress will be completed (dictated) the day of the visit.
3) Upon admission a Psychiatric Evaluation will be conducted and documented in the individual served record.
4) Prescriptions will be documented on the organization's approved prescription forms and filed in the record.
5) Orders for lab work and notation of review of lab work will be documented in the progress notes.
6) When equipment failure prevents adequate diagnosis or treatment, a progress note should be written to document such failure.

G. MEDICAL RECORDS

1) Medical Records staff will ensure that current and accurate psychiatric, diagnostic, medical, and medication information is made available/accessible for routine care and in emergency situations.
2) If the record is kept at the site where the individual served is being seen, arrangements will be made to have a copy of the record as well at the site of the treating clinician not only for routine care but in case of emergencies.
3)

H. TRAINING, LICENSURE AND LIABILITY

1) All staff members involved in the operation of the system and provision of the services will demonstrate competency in the system's operation (including equipment operation and limitations and means of safeguarding confidentiality and security).
2) Psychiatrists will be credentialed through Human Resources to ensure licenses and liability insurance are current.

I. EQUIPMENT FOR VIDEOCONFERENCING

1) At a minimum, equipment used will comply with HIPAA guidelines for telemedicine.
2) ACR's IT consultant will contact to ensure that all telemedicine equipment used meets HIPAA guidelines.

J. QUALITY OVERSIGHT/MONITORING

1) Quality oversight of the service will be provided by the Quality Assurance and Compliance Director through annual reviews of documentation and monitoring of telemedicine practices.

2) Individual served s participating in telemedicine psychiatric services will be asked to complete a satisfaction survey on an annual basis. Sample questions that may be asked include, but are not limited to the following:
    a. Was it easy to schedule an appointment?
    b. Were your privacy and confidentiality protected during the telemedicine psychiatric service?
    c. Were you able to communicate adequately with the doctor?
    d. Were the picture and sound O.K.?
    e. Was the doctor on time for the appointment?
    f. Was the nurse there to assist you if needed?
    g. Overall, are you satisfied with the telemedicine psychiatric services?

K. SPECIFIC OPERATING PROCEDURES

1) Scheduling of appointments for telemedicine psychiatric services will be handled by ACR's medical assistant.
2) Prescriptions will be sent to the pharmacy using E-prescribe if applicable.
3) At the conclusion of the service the psychiatrist will complete a progress note and assign appropriate codes for Individual served payment functions.

Attached: Telemedicine Informed Consent Form (ACR Form 25.21.a)

Policy 27.01 - Records of the Person Served

I. POLICY:

A. It is the policy of ACR to develop and maintain a complete and accurate record to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served.

II. PROCEDURES:

A. The individual record of each person is maintained in such a manner as to protect the confidentiality and integrity of the record. The guidelines for this process are as follows:

1) Each record will be issued an identifying number upon the first admission to any of ACR'S services or programs. This number will be uniform throughout all services and dates of services provided.

2) Individual records will be maintained at 2568 Park Central Blvd, Decatur, GA 30035.

3) All records will be maintained in a systematic fashion that follows a standard format for record organization established by ACR.

4) Documentation in the individual record will be clear and legible.

5) All information in the record will be current and complete, and documents that require signatures will contain original or electronic signatures.

6) To maintain uniform individual records that protect the integrity of demographic, financial, and clinical information, the individual records will be assembled according to the following guidelines:

a. The individual record is defined as all information collected and used regarding an individual seeking services from ACR.

b. The individual record will contain three distinct types of information: demographic, financial, and clinical.

c. The assembly of the record is initiated upon admission to services and/or programs.

d. Upon discharge from ACR the individual record is assembled into a final order according to the established standard closed record format.

e. A complete listing of closed records that have been disassembled according to procedures and removed to storage areas will be maintained in the records room.

7) Individual records will be retained for 7 years after the most recent discharge date.

8) All preadmission screening forms of persons not admitted to ACR will be retained for 7 years. If the form has no identifiable information regarding the person served, it will be destroyed in one year. External referral forms for referrals to ACR will be included in the record for persons admitted and will be retained for at least 7 years.

B. All individual records will contain, at a minimum, the following information:

1) The date of admission.

2) The name, address, and telephone number of the person's representative, conservator, guardian, or representative payee, if appointed.

3) Emergency contact information including a name, address, and telephone number.

4) The name of the person coordinating services.

5) The name, address, and telephone number of the person's primary care physician.

6) Health care reimbursement information.

7) The person's health history, current medications, admission screening, documentation of orientation, assessments, and individual plan and reviews.

8) A transition plan, when applicable

9) A discharge summary that:

    a. Includes the person's diagnosis or disability/disorder.

    b. Identifies the presenting condition.

    c. Describes the extent to which established goals and objectives were achieved.

    d. Describes the services provided.

    e. Describes the reasons for transition/discharge.

    f. Identifies the status of the person served at discharge/transition.

    g. Lists the recommendations for services or supports.

    h. Includes the dates of admission.

    i. Includes the date of transition from the program.

10) Any correspondence pertaining to the person served.

11) Authorization for release of information.

12) Documentation of internal or external referrals.

C. To ensure that records are maintained in a uniform manner, are secure, and are available to support continuity of care, the following guidelines will apply:

    1) All records will be filed, secured, and retrieved by the records staff. Exceptions will include designated personnel at service locations where the record is on-site and maintained by the clinical staff. Those locations will follow site-specific procedures that limit access to the records and that require the records are maintained in a secure fashion.

2) The Quality and Compliance Officer will be responsible for controlling the records and implementing policies and procedures pertaining to the records.

3) Records maintained by the records staff will be kept in a secured area with access limited to only designated records staff. The records area will be secured by lock at any time records staff are unable to remain within the area. Only records staff and designated supervisory personnel will have access to keys to the area. A designated staff member will be available and known to all staff in order to access the records after hours and in case of an emergency.

4) All records maintained at service locations by clinical staff will be secured in a locked file cabinet. If the record is in a staff office, that office will be locked when not occupied.

5) If a secondary or "working record" is maintained at a satellite office, in addition to the primary record, it will be maintained according to the safeguards contained in this policy, and the record will be limited to the following information:

    a. Screening, referral, and assessment information.

    b. Program admission form.

    c. Individual plan and subsequent reviews.

    d. Emergency medical information to include:

        1. The name, address, and telephone number of the person's physician.
        2. The name, address, and telephone number of the person to be notified in case of an emergency.
        3. Medical insurance identification.
        4. Medication used.
        5. Medication and food allergies.
        6. Significant medical problems.

    e. The location of primary medical record.

    f. All other requirements as outlined by regulatory and accreditation bodies.

6) All records utilized by community-based providers will be maintained in a locked case, container, or brief case. Community-based providers will be informed during orientation of procedures for maintaining records outside of ACR'S facilities.

7) All records will be kept in areas that provide reasonable protections from fire, water damage, and other hazards.

8) Records will be made available in a timely manner to authorized personnel by the records staff for scheduled appointments, for documentation purposes, and for reviews upon request.

9) The record will be tracked to individual staff members who will be responsible for safeguarding the record and doing their own filling before the end of the business day.

10) The filing of all loose materials in the record is a function of the records or other designated staff. The filing is to be kept current and will be placed in individual records within three working days. All loose filing will be kept in a container designated as "to be filed" within a secured records area/room or staff office if at a service location.

11) Any loose filing that cannot be identified will be turned over to the Quality and Compliance Officer. The material in question will be identified through exploration with service providers of content contained in the materials.

12) All data files maintained in electronic systems will be backed up on a daily basis and will be securely preserved at a separate location from the regular files.

13) All electronic record files maintained in any manner on ACR'S electronic data system are subject to the policy and procedures regarding electronic records.

14) If records need to be transported to a different location, such as court proceedings, records will be placed in a sealed manila envelope or boxes marked "confidential" and placed in the locked trunk of a car for transportation to the destination. The Quality and Compliance Officer is responsible for safeguarding the records while they are in transport. At no time will the records be left unattended.

D. Records will be audited on a quarterly basis by the records staff to ensure that ACR maintains and processes record information in compliance with rules, regulations, and organizational policy and procedures. The following criteria will be used to evaluate the record management process:

    1) A representative sample of records will be pulled from the active files on a monthly basis.

    2) Records sampled will have intact record covers and labels that reflect allergies, payment method, and medication restrictions, when warranted.

    3) Records in the sample will have all information filed according to the current record organization guidelines.

    4) All documents and forms within the record will contain the appropriate dates, signatures, and authorizations.

    5) The “loose/to be filed” documents will not contain dated material older than three working days.

    6) The record tracking system will reflect the status and location of each sampled record.

    7) All data in an individual’s database will be reflected in the documentation in the medical record.

    8) The records staff or appropriate service provider will correct any problems discovered during the audit.

    9) Patterns and trends will be tracked to identify any processes that may need corrective action and will be reported to the CEO.

E. Documentation in records will be consistent, directly related to services provided, and in compliance with legal, risk management, and clinical care standards. The following guidelines apply to documentation in the record:

    1) Written documentation will be completed in black or blue ink only.

    2) All written documentation will be clear, concise, accurate, and legible.

3) All entries will be made in a timely fashion to increase accuracy of documentation.

4) Entries will occur immediately after the service is performed.

5) Any late entries will be documented using the actual date the note is written with a reference to the exact date the service occurred.

6) If a mistake is made in the record, a single line will be drawn through the incorrect information, “error” will be written above the entry, and the provider’s initials and date will be noted. Liquid paper, or any kind of marking over an error so it cannot be read, is not appropriate in any circumstance as it may invalidate the entire record in a legal proceeding.

F. All records will be destroyed in accordance with federal and state law and ACR’S guidelines for retention and destruction as follows:

1) All records involved in any investigation, litigation, or audit will not be destroyed until legal counsel has confirmed that no further legal reason exists for retention of the record.

2) In the event a legal proceeding is initiated against ACR, the records staff will be notified immediately by the CEO to stop the destruction of files.

3) Prior to the destruction of records, the following information will be gathered from the record and permanently maintained for all persons served:

a. Person’s name.

b. Social Security number.

c. Date of birth.

d. Dates of admission and discharge.

e. Name and address of legal guardian, if any.

4) All records will be destroyed in a manner that eliminates the possibility of reconstruction of the information.

5) Paper records will be destroyed by one of the following methods: shredding, burning, pulping, or pulverizing.

6) Microfilm and microfiche will be destroyed by recycling or pulverizing.

7) Computer files will be permanently destroyed through reformatting the disc or overwriting the data. Deleting files will not be utilized as the information remains within the system. In addition, all back-up tapes of records will be overwritten.

8) Any CD-RW disks that contain document imaging that cannot be overwritten will be destroyed through pulverization.

9) All activities related to the destruction of records will be documented and maintained by the records staff. The following information will be included in the documentation of the destruction:

    a. The date of the record destruction.

    b. The method of destruction.

    c. A description of the records that were destroyed.

    d. The start and end date of the records.

    e. The signatures of the individual conducting the destruction and of the witness of the action.

9) Any contracted services for the destruction of ACR'S records will be provided according to the following contractual guidelines:

    a. The method of destruction will be specified.

    b. The time between the acquisition and destruction of the records will be specified.

    c. Established safeguards to protect the confidentiality of the records will be described and noted.

d. Appropriate insurance coverage will be maintained and documented by the contractor to protect ACR from loss in the event of an unauthorized disclosure.

e. The contractor will provide proof of destruction.

Forms:

- **Health Information Disclosure Tracking Log**
- **Requests for Accounting of Disclosures**

HEALTH INFORMATION DISCLOSURE TRACKING LOG

Client Name: Client Identifier:

Date request received	Name of Requestor*	Address (if known)*	Authorization or written request type	Purpose of Disclosure*	Health information Disclosed*	Disclosed by:	Date Disclosed*

Fields required by HIPAA Privacy regulations. Fields can be used in a computerized record or tracking system.

KEY:

Date request received: the date request is received to disclose or release information when applicable **Name of Requestor:** name or entity or person requesting information to be disclosed or released **Address:** if known, the address of the entity or person requesting information to be disclosed or released

Authorization or written request type: identify if there is a written request or authorization including court orders and subpoenas; If not, indicate how request was received

Purpose of Disclosure: brief description of the purpose of the disclosure to reasonably inform about the basis of the disclosure; if documented on authorization form or other document, state "See authorization/written request"

Health information Disclosed: brief description of actual information disclosed

Disclosed by: staff member processing the request and authorized to make the disclosure

Date disclosed: date the information was disclosed

REQUESTS FOR ACCOUNTING OF DISCLOSURES				
Requested by Patient/Legal Representative	Date Requested	Date range requested	Staff completing request	Date Provided

Policy 27.02 - Approved Abbreviations

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) that only approved abbreviations should be used in consumer's clinical records so that there will be no confusion or inaccuracy arises from the use of non-standard abbreviations.

II. The Joint Commission Official "Do Not Use" List:

Whenever there are conflicts between ACR's Official List of Abbreviations and The Joint Commission Official "Do Not Use" List; the **Joint Commission Official "Do Not Use" List (ACR Policy 25.19) will take precedence.**

III. Official List of Abbreviations

A
AA = Alcoholics Anonymous
AACP = American Association of Community Psychiatrist
AAA = Area Agency on Aging
ARA = Assault Risk Assessment
AB = absent
AC = Before meals
ACT = Assertive Community Treatment
ADI = Adolescent Drinking Index
ADB = as demonstrated by
A&D or AD = Alcohol and drug
ACTO = Atkinson County
ADA = Americans with Disability Act or Average Daily Attendance
ADHD = Attention Deficit Hyperactivity Disorder
ADD = Attention Deficit Disorder
ADL = Activities of daily living
APA = American Psychiatric Association
AEB = as evidenced by
AIMS = Abnormal Involuntary Movement Scale
Apt Mgr = Apartment Manager
ARC = AIDS-related complex
ARA = Assault Risk Assessment
Acctg = Accounting
Adm = Administrative
APS = American Psych Systems or Adult Protective Services
ASA = Asprin
ASI = Addiction Severity Index

ASAM = American Society of Addiction Medicine
AMA = Against Medical Advise
ASAP = as soon as possible

B

BS = Behavior Specialist
BH = Behavioral Health
BHL = Behavioral Health Link
BID = Two Times Daily
BIF = Basic Intake Form
B/F = Black Female
B/M = Black Male
BPS =Biopsychosocial
BPRS = Brief Psychiatric Rating Scale
BST = Behavioral Support Team
BWE = Blind Work Expense
BHP = Behavioral Health Professional

C

c with line over top = with
C&A = Child and Adolescent
CAC = Certified Addiction Counselor
CAFAS = Child and Adolescent Functional Assessment Scale
C&E = Consultation and Education
CDR = Continuing Disability Review
CID = Client Identification Number
Clerk, Gen I = Clerk, General I
Clerk, Gen II = Clerk, General II
CD = Consumer Direction
CM = Case Manager
CMS = Centers for Medicare and Medicaid Services
CCO = Corporate Compliance Officer
CAP = Corrective Action Plan
CARF = Commission on Accreditation of Rehabilitation Services
CDR = Continuing Disability Review
CE = Case Expeditor
CEO = Corporate Executive Officer
CIS = Computer Information System
CIWA = Clinical Institute Withdrawal Assessment for Alcohol
CLA = Community Living Arrangements
CMC = Children's Medical Center
CMHC = Center for Mental Health Services
CoC = Continuum of Care
Comp Waiver = Comprehensive Waiver
CMO = Care Management Organization
COA = Council on Accreditation of Services for Families and Children
CP = Chest Pain
CPS = Child Protective Services
CR or CSR = Consumer
CST = Community Support Team
CRS = Community Residential Services
cs = consecutive
CS = Community Supports
CSOP = Community Support Organization Plan
CSI = Community Support Individual

CSU = Crisis Stabilization Unit
CSP = Crisis Stabilization Program
CTA = Clear to Auscultation
CUT = Chronic Undifferentiated Type
COTR = Clinical Options Treatment Request
CW = Community Worker

D

DAISY = Diversified Agencies Involved in Serving Youth
DBT = Dialectical Behavioral Therapy
DD = Developmental Disability
DDP = Developmental Disability Professional
DT = Day Treatment
DCA = Department of Community Affairs
DCH = Department of Community Health
DDBS = Deputy Director of Behavioral Services
DDCS = Deputy Director of Community Services
Detox = Detoxification
Day Hab = Day Habilitation
DHR = Department of Human Resources
DFACS or DFCS = Department of Family and Children's Services
DJJ = Department of Juvenile Justice
DLA = Daily Living Activities Scale
DMA = Department of Medical Assistance
DMHDDAD = Division of Mental Health, Developmental Disabilities, and Addictive Disease
Dir, T&WC = Director of Training and Work Center
DOAS = Department of Administrative Affairs
DOB = Date of Birth
DOS = Date of Service
DOL = Department of Labor
DRS = Department of Rehabilitation Services or Designated Record Set
DS = Day Support
DSC = Developmental Services Center
DSM = Diagnostic and Statistical Manual (IV-TR = Fourth Edition-Text Revision)
DTH = Developmental Training Home

E

EARF = Enrollment Addition and Release Form
EBP = Evidence-Based Practice
ED = Educational
EIS = Early Intervention Specialist
EL or E-Learning = Essential Learning
Emp = Employed
EMG = Emergency
EMR = Educable Mentally Retarded
ESP = Employment Service Plan
ER = Emergency Room
Eval = Evaluation

F

FA = Fiscal Agent
FBR = Federal Benefit Rate
FCP = Family Centered Planning
FI = Fiscal Information
FY = Fiscal Year

G
GAF = Global Assessment of Functioning
GCAL = Georgia Crisis and Access Line
GCDD = Governor's Council on Developmental Disabilities
GED = Graduate Equivalency Diploma of General Educational Development
GH = Group Home
GIA = Grant in Aid
GRH-S or GRH = Georgia Regional Hospital-Savannah

H
HH = Host Home
HIPAA = Health Insurance Portability and Accountability Act
HP = Houseparent
HR = Human Resources
HRST = Health Risk Screening Tool
hs = Bed Time or Hours of Sleep
HST = Health Service Technician
HUD = Department of Housing and Urban Development
Hx = History

I
ICDM = International Classification of Disease Manual
ICN = Internal Control Number
I&E = Intake and Evaluation
ID =Identification
IEP = Individual Educational Plan
IFI = Intensive Family Intervention
IOM = Institute of Medicine
IRP = Individualized Recovery Plan
ISP = Individualized Service Plan
ISRP = Individualized Service and Recovery Plan
Inst Aide = Instructor Aide
Inst = Instructor
Inst Sr = Instructor, Senior
Inst Pr = Instructor, Principle
IRWE = Impairment Related Work Expenses
IT = Individual Therapy
IWRP = Individual Work Rehabilitation Plan

J
JCAHO = The Joint Commission on Accreditation of Healthcare Organizations
JC = Job Coach
JD = Job Development

L
LAMFT = Licensed Associate Marriage and Family Therapist
LAPC = Licensed Associate Professional Counselor
LCSW = Licensed Clinical Social Worker
LD = Learning disability
LMFT = Licensed Marriage and Family Therapist
LMSW = Licensed Marriage Social Worker
LOC = Level of Care
LOCUS = Level of Care and Utilization Scale
LPC = Licensed Professional Counselor

LPN = Licensed Practical Nurse
LPC = Licensed Professional Counselor

M
MAPS = Making Action Plans
MAST = Michigan Alcoholism Screening Test
MATCH =
MICP = Multipurpose Information Consumer Profile
MH = Mental Health
MHC = Mental Health Center
MHP = Mental Health Professional
MM = Medication Maintenance
MMPI = Minnesota Multiphasic Personality Inventory
MR = Mental Retardation
MRP = Mental Retardation Professional
MRS = Mental Retardation Specialist
MRWP = Mental Retardation Waiver Program

N
N/A = Not Applicable
NA = Narcotics Anonymous
NCQA = National Council on Quality Assurance
NOS = Not Otherwise Specified
NSE = Natural Support Enhancement

O
OA = Operations Analyst
OCGA = Official Code of Georgia
ODD = Office of Developmental Disabilities
ORS = Office of Regulatory Services
OTC = Over the Counter
OTP = Outdoor Therapeutic Program

P
p = After
PA = Physician Assistant
PASS = Plan for Achieving Self Support
pc = After meals
PCP = Primary Care Physician/Provider or Person Centered Planning
PCH = Personal Care Home
PERMES = Performance Measurement and Evaluation System
PGOI = Problems, Goals, Objective, Interventions
PHC = Private Home Care
PHI = Protected Health Information
PHN = Public Health Nurse
PI = Performance Improvement
PO = By Mouth
POS = Place of Service
PPD = Tuberculosis Skin Test
PRTF = Psychiatric Residential Treatment Facility
PS = Personal Support
PSP = Peer Support Program
PSR = Psychosocial Rehabilitation
Psych't = Psychiatrist

Q

q = every
QAM = Every Morning
QHS = Every Night at Bedtime
QID = Four Time Daily
Q4H = Every Four Hours

R

Rep Payee = Representative Payee
RFW = Ready for Work
RMP = Recovery Management Plan
R/O = Rule Out
RO = Regional Office
RN = Registered Nurse
RN, L = Registered Nurse, Lead
RPh = Registered Pharmacist
RTS = Residential Training and Supervision
RTC = Return to Clinic
RYDC = Regional Youth Development Center

S

s with line over top = Without
SA = Substance Abuse
SB = Support Broker
SC = Support Coordinator
SD = Self Determination
SO = Sheriff's Office
SAC = Substance Abuse Counselor
SAM = Substance Abuse Manager
SAP = Substance Abuse Professional
SAS = Substance Abuse Supplemental
SASSI = Substance Abuse Subtle Screening Inventory
SCS = Satilla Community Services or State Contracted Services
SIS = Supports Intensity Scale
SE = Supported Employment
Sec I = Secretary I
Sec II = Secretary II
Sec III = Secretary III
SED = Severely Emotionally Disturbed
SEP = Supported Employment Program
SEP, Cord = Supported Employment Coordinator
SG = Support Group
SGA = Substantial Gainful Activity
SGC = South Georgia College
SLA = Semi-independent Living Arrangement
SMART = Simple, Measurable, Attainable, Realistic, and Time-Frame
SNAP = Strengths, Needs, Abilities, and Preference
SOAP = Subjective, Objective, Assessment, Plan
Sp Ed or SPED = Special Education
ss = Half
SS = Social Security
SSA = Social Security Administration
SSC = Social Service Coordinator
SSDA = Social Security Disabled Adult Child
SSDI = Social Security Disability Insurance/Income

SSI = Supplemental Security Income or Insurance
SIDS = Sudden Infant Death Syndrome
SPC = Shelter Plus Care
SRS = Structured Residential Supports
SSC = Social Services Coordinator
SSP = Social Services Provider
SSP, II = Social Services Provider II
SST = Social Services Technician
SST, II or Sr = Social Services Technician, Senior
SST, III or Pr = Social Services Technician, Principle
Svcs = Services
SWOT = Strengths, Weaknesses, Opportunities, Threats
Sxs = Symptoms

T
TANF = Temporary Assistance for Needy Families
TAPP = Treatment and Aftercare for Probationers and Parolees
TDD/TTY = Telecommunications Devise of the Deaf/Text Telephone
TFC = Therapeutic Foster Care
TI = Training Instructor
TI, II or TI, Sr = Training Instructor, II or Training Instructor, Senior
TID = Three Times Daily
TWP = Trial Work Period
TRIGRS = Treatment Request and Integrated Reporting Survey
Tx = Treatment

U
UM = Utilization Management

V
VA = Veteran's Administration
VO = Verbal Order
VR = Vocational Rehabilitation

W
WA = Work Activity
WAIS = Wechsler Adult Intelligence Scale
WAIS-R = Wechsler Adults Intelligence Scale-Revised
WI = Work Incentive
WIC = Work Incentive Counselor
WIP = Work Incentive Program
WINGS = Women Incorporating New Goals
WISC = Wechsler Intelligence Scale for Children
WISC-R = Wechsler Intelligence Scale for Children-Revised
WISC-III = Wechsler Intelligence Scale for Children-III
W/F = White Female
W/M = White Male
WNL = Within Normal Limits
WPPSI = Wechsler Preschool Primary Scale of Intelligence
WPPSI-R = Wechsler Preschool Primary Scale of Intelligence-
WPT = Work Preparation Technician
WRT = With Regards To
w/ = with
w/o = without

X
xs = times

Y
YDC = Youth Development Center
Y/O = year old

Symbols
& = and
i with a line = One Tablet or Capsule
ii with a line = Two Tablets or Capsules
iii with a line = Three Tablets or Capsules

Note: Periods have been omitted from abbreviations, but are acceptable. Universally understood abbreviations, such as those for days of the week, months of the year, and the states are acceptable.
Approved by:

Policy 27.03 - Clinical Record Creation, Content Order, Thinning and Closing

I. POLICY:

It is the policy of Assertive Community Recovery, LLC (ACR) to maintain a comprehensive medical record for each individual admitted to a service. The medical record is the collected documentation of the following types of information for individuals served by the agency: demographic, legal, authorization, financial, treatment planning and service delivery (medical, assessment, referral, diagnostic, intervention). A medical record is established on an individual basis and identified by full name and case number. Records may be maintained in more than one format, i.e. folders or binders.

II. PROCEDURES:

A. Intake and Opening a Clinical Record

1. A clinical record will be opened whenever a person is assessed to determine the need for further services. Enrollment in a ACR program will also constitute admission to ACR. All necessary paperwork and data entry for intake is required. This is done for individuals who are new to ACR, for former individuals returning to ACR for services after being previously discharged, and for persons prescreened by ACR, admitted to the state hospital and requiring liaison services. This will be done at the time of the first contact (by telephone for pre-admission data collection, face to face, or emergency contact..
2. If services are provided during a crisis/emergency but the person is otherwise not deemed eligible or appropriate for further ACR services, or receive a screening but are not seen again, the person will be admitted to the ACR and may then be discharged or placed on inactive status pending future services. If the crisis intervention is provided to an active ACR individual, the crisis material will be incorporated into the primary medical record that is already open.
3. Each individual admitted for services at ACR will be assigned a medical record number and a single primary record will be established. In most cases, the primary record will be the case management record. For individuals who do not receive case management, the primary record will be the program record. All other records will be considered as program records. A program record will be opened when the individual meets eligibility criteria for an available program and requires ongoing services.
4. A separate medical record will be maintained for each person or family member who is receiving individual treatment. The medical record is the property of ACR; however, the information in the record belongs to the individual.

5. Exceptions to opening a medical record is when the person is assessed for a waiting list but receives no other services.

B. Opening a New Record for a Former Individual Returning for Services

1. A new medical record will be created for each new admission of a person who has been formally discharged from ACR. This will create a new episode of care. New paperwork, including new assessments, a new treatment plan, etc., is required in order to address the individual's current situation and issues pertinent to the new episode of care. If there are recent crisis records or recent evaluations which are pertinent to the current episode of care and which are not already part of a medical record, these should be incorporated into the new medical record.
2. When a former individual is readmitted to ACR and/or program, the closed record should be used as a historic reference. After use, the closed record must be returned to closed record storage.

C. Purposes of the medical record:

1. To document the assessment of individual need/eligibility, functioning, strengths, abilities and preferences,
2. To serve as a basis for planning individual care and for continuity in the evaluation of the individual's condition and treatment,
3. To furnish documentary evidence of the course of evaluation, treatment and change in condition,
4. To document communication between the service provider and any other allied professionals who contribute to individual care,
5. To assist in protecting the legal interest of the individual, ACR, and the clincian(s) who are responsible for providing care, and
6. To provide data for use in research, billing, and accountability.

D. Content of the medical record:

1. Needs to be safeguarded against loss, defacement, tampering and use by unauthorized individuals.
2. Is sufficiently detailed and comprehensive to enable a service provider/consultant/reviewer to determine the individual's condition during and following care, and the individual's response to interventions
3. Permits retrieval of information required for reimbursement, quality assurance/peer review and utilization review

E. All medical records will be maintained according to the approved Record Format.

1. The Record Format establishes the documents that must be in each case management record and each program record.
2. The Record Format indicates how long each document must be maintained in the current primary or program record before it may be thinned and placed into

an overflow record as described in Section 6 below. Some documents may not be thinned.

F. Thinning medical records - creation of overflow medical record volumes

1. The Program Manager will authorize the creation of overflow volumes for each individual.
2. The medical record will be thinned as needed or by calendar year by assigned program staff according to the approved thinning schedule. The following documents must remain in the current "active" medical record: (that is, must not be purged to overflow volume(s):
    a) Initial assessment that established eligibility for the service;
    b) Initial ISP that established need for the service;
    c) The current assessment, as well as the assessment preceding the current one;
    d) The current ISP(s) as well as the ISP preceding the current one;
    e) Last 4 quarterly ISP reviews;
    f) At least 6 months of progress notes; and
    g) At least 6 months of physicians' notes and order sheets.
3. Each year's thinning should be filed in a separate volume. A label will be placed on each overflow record to include:
    a) 1. Individual name,
    b) 2. Chart number,
    c) 3. Volume number, and
    d) 4. Date range.

    Example: Mary Smith, Case No. 123456789

    Overflow Volume 1, January 1999 to December 1999
4. The inactive overflow volumes containing thinned documents will be filed alphabetically and will be readily accessible. The same confidentiality and security considerations apply to these as to active medical records.

G. Program Dis-enrollment, Inactive Case Status, Case Reactivation, and ACR Discharge

Note: A individual remains on active status so long as there has been at least one (1) face-to-face contact within the last 90 days.

1. Program Discharge/Dis-enrollment (A Program Discharge)
    a) A individual will be dis-enrolled from a program when:
    b) 1. He/she has completed the program and no longer needs that service, or

c) 2. There has been a period of 90 days since the last face-to-face service, and

d) 3. The case manager has contacted the individual in writing at least 10 days before dis-enrollment, indicating the ACR's intent to discontinue services (dis-enroll them) and provided the Medicaid form when applicable ("Notification of Right to Appeal Action") informing the individual of his/her right to appeal this decision.

e) He/she has been discharged from ACR.

2. After the individual is dis-enrolled, the record will be closed. The program discharge paperwork will become due after the ACR inactive status period or after the individual is discharged from ACR, whichever comes first:

a) Program Discharge Transition Summary,(within 30 days of closure)

b) Data update in applicable individual management systems

H. Inactive ACR Status

1. For individuals who have received any ACR service in addition to case management services, the case manager will place the individual's record on inactive ACR status when:

a) The case manager has not provided face-to-face services within the last 90 days, and

b) The individual is expected to return for additional services within the next 90 days, and

c) The individual has been dis-enrolled from all other ACR programs.

2. At the discretion of the agency, a case may then remain on inactive status for an additional 90 days (up to 180 days from the last face-to-face service) but no longer. After 180 days, the episode of care is deemed over and the case must be closed (an ACR discharge).

Note: It is not mandatory that a case be placed in inactive status prior to ACR discharge. The inactive period is available for those individuals with a history of needing services for the same episode of care over a long period of time and for those whose attendance is intermittent such as when short-term inpatient hospitalization is needed.

3. Using the monthly report on individuals not receiving services within the last 90 days, the case manager will identify those individuals who will be placed on inactive status. The data entry staff will then update applicable computer systems to reflect the change from active to inactive status.

I. Reactivation of an Inactive Case

A case that is inactive can be returned to active status by the case manager if the following conditions are met:

1. The individual needs additional and available program and/or case management services from ACR for the same episode of care.
2. The inactive status has not exceeded 180 days since the last face-to-face service.
3. The individual has not yet been discharged from ACR.
4. Using the monthly report on individuals not receiving services within the last 90 days, the case manager will identify those individuals who will be placed on inactive status. The data entry staff will then update applicable computer systems to reflect the change from inactive to active status.

J. ACR Discharge:

A individual will be discharged from the ACR and a ACR transition discharge summary (will be completed within 30 days whenever the following conditions are met:

1. No further ACR services are needed (as determined by the case manager), and
2. The person has been dis-enrolled from all ACR programs, ACR contracted services and case management, or
3. The person has relocated out of the ACR service area or has died, or
4. The case has reached the 180-day point since the last face-to-face service, AND
5. When applicable and 10 days prior to discharge, the case manager has provided the individual with written notification (pursuant to current Medicaid procedures) of his right to appeal the action (using "Notification of Right to Appeal Action").
6. The discharge paperwork includes:
    a) Completion of all Program Transition Discharge Summaries
    b) Completion of MICP Discharge Summary as applicable https://careconnection.apshealthcare.com.
    c) Data entry into applicable ACR computer systems to close out the case and change the status from either active or inactive (as applicable) to closed/discharged.

K. A closed primary medical record

1. A closed medical record will be composed of the same documents that were applicable when it was an active record. To this will be added the applicable program and/or ACR transition discharge summaries. The main record and the overflow record volumes will be moved to the closed record storage area and filed together.
2. A medical record will be maintained, and retained for a minimum of six (6) years from the date of its creation or the date when last in effect (whichever is later).

L. ACR Staff responsibilities

The service provider (including the case manager) is responsible for ensuring that the required information on each individual admission is communicated to data entry staff and input accurately and promptly into the ACR computerized individual data system. The service provider and his/her supervisor are responsible for ensuring that all information in Sharenote system and the clinical record is current, correct, complete and updated as required.

Policy 27.04- Designated Record Set

POLICY:

To comply with the Health Insurance Portability and Accountability Act (HIPAA), Administrative Simplification provisions, Assertive Community Recovery (ACR) will maintain the following items in its designated record set of protected health information (PHI):

A. The Medical Record, including all of the items listed below, and any other records of care that would be appropriate:

1. the clinical diagnostic assessment
2. the psychiatric diagnostic assessment
3. the treatment plan
4. consents for treatment
5. reports from indirect treatment providers
6. functional status assessments
7. medication profiles
8. progress notes and documentation of care provided (for both treatment and reimbursement purposes). (This would not include all residential shift notes or other notes kept in the residential record or in a log book maintained at the site.)
9. multidisciplinary progress notes/documentation
10. content of any consultation with internal or external individuals regarding the client's care
11. nursing assessments
12. orders for diagnostic tests and diagnostic study results
13. practice guidelines that imbed patient data
14. records of physical history and examinations
15. respiratory therapy, physical therapy, speech therapy, occupational therapy records, and any other records of services provided by specialty providers
16. telephone consultation records
17. telephone orders
18. discharge instructions
19. discharge summaries
20. legal documents and correspondence between the agency and the client or others involved in the client's care
21. utilization management or utilization review forms that are used to determine or review level of care decisions including admission, continuing stay, and discharge

B. The Billing Record

1. Signature on file
2. Consent to bill third parties

3. Individual Financial Hardship Assessment
4. Copies of any insurance cards and other data on insurance coverage
5. Fee Agreement
6. Requests for prior authorization of services
7. Authorizations for services or other written acknowledgements of client eligibility for services
8. Billing records including dates, services provided, provider, billing and payment records, and other information used to bill or to record and report encounters or services.

PHI is kept in many forms throughout our agency. Each of the existing repositories of PHI have been identified, documented, and approved for usage. It is our policy that any new need for creation of an additional repository of PHI must follow the same process. Unsanctioned maintenance of PHI in any form will lead to disciplinary action.

BACKGROUND / PURPOSE:

ACR, in an effort to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the elements of the designated record set and the creation and maintenance of data sources that contain protected health information (PHI). This Policy mandates that the Agency maintain accurate and complete medical and billing records for each of our clients so that they can exercise their rights to access, review, and amend their PHI maintained in a designated record set as required under HIPAA.

IMPLEMENTATION / PROCEDURE:

Every consumer will have a medical record and a billing record that together will comprise the "designated record set" for the client.

1. If an employee or contactor of ACR is not sure if a certain document or piece of information belongs in the designated record set they should contact their supervisor or the Privacy Officer for advice.
2. If an employee or contractor believes that there are documents in a client's designated record set that do not belong there, he/she should contact their supervisor or the Privacy Officer for advice on how to proceed.
3. Medical Records:
    a. The medical record will be created, stored, and secured according to agency policy, licensing requirements, and the accreditation standards of CARF and will contain, at least, the following information:
        1. the clinical diagnostic assessment
        2. the psychiatric diagnostic assessment
        3. the treatment plan
        4. consents for treatment
        5. reports from indirect treatment providers
        6. functional status assessments
        7. medication profiles

8. progress notes and documentation of care provided (for both treatment and reimbursement purposes). This does not include residential shift notes maintained in a log book or in another such form but does include the medical record maintained at the site
9. multidisciplinary progress notes/documentation
10. content of any consultation with internal or external individuals regarding the client's care
11. nursing assessments
12. orders for diagnostic tests and diagnostic study results
13. practice guidelines that imbed patient data
14. records of physical history and examinations
15. respiratory therapy, physical therapy, speech therapy, occupational therapy records, and any other records of services provided by specialty providers
16. telephone consultation records
17. telephone orders
18. discharge instructions
19. discharge summaries
20. legal documents and correspondence between the agency and the client or others involved in the client's care
21. utilization management or utilization review forms that are used to determine or review level of care decisions including admission, continuing stay, and discharge

b. All of the information in the medical record that is used to make decisions about the individual will be a part of the designated record set.
c. Employees and contractors who create or handle the PHI that will become a part of the medical record or who have access to the medical record have certain responsibilities. They include:
    1. All PHI created by an employee or contractor of agency should comply with agency policy and regulation on content, dating and appropriate signatures.
    2. All PHI required to be created by an employee or contractor should be completed as soon as possible and at least within the time frames designated by agency policy on medical records or other applicable policy.
    3. Any PHI obtained from a third party by an employee or contractor that should be filed in the medical record should be reviewed as soon as possible for relevant content and placed in the appropriate place to be filed in the medical record or should be filed by the employee or contractor who received the third party PHI.
    4. Any PHI that must be filed in the medical record should be filed on a timely basis, in date order and in the appropriate section of the medical record.
d. Clinical or direct service staff who wish to create a supplementary client record for their use in the community or at satellite sites that includes copies of any

part of the medical record or any other PHI must obtain the prior approval of the Privacy Officer.

4. Billing Records
    a. The billing records of the agency will be created, maintained and secured according to agency policy, licensing requirements, and the accreditation standards of CARF and will contain the following information:
        1. Signature on file
        2. Consent to bill third parties
        3. Individual Financial Hardship Assessment
        4. Copies of any insurance cards and other data on insurance coverage
        5. Fee Agreement
        6. Requests for prior authorization of services
        7. Authorizations for services or other written acknowledgements of client eligibility for services
        8. Billing records including dates, services provided, provider, billing and payment records, and other information used to bill or to record and report encounters or services.
    b. The responsibility for maintaining the billing record is shared by a number of departments in the agency. This includes clinical services who often hear from clients first about changes in insurance or financial status and are responsible for completing certain documents in the billing record such as requests for service authorizations.
    c. Each employee or contractor who is responsible for obtaining or maintaining any of the billing records is responsible for:
        1. Ensuring that the information is complete, communicated to the appropriate person, and filed (or entered into the billing database) in a timely manner.
        2. Ensuring that the information is appropriately secured according to agency policy

No employee or contractor should maintain any of the information contained in the billing record in a separate file or outside of the locations designated in agency policy. However, in certain circumstances an employee may be asked to obtain billing information in a community location or at a satellite site. In these cases, the information should be secured until it can be given or communicated.

Policy 28.01 - Quality Records Review

I. POLICY:

It is the policy of ACR to conduct fair and equitable reviews of records to provide useful and constructive feedback in a format that can be utilized to improve the quality of services. The reviews will address the quality of service delivery, the appropriateness of services, and the patterns of service utilization. The results of the review process will be used to assist service providers to improve practices and ensure the organization is utilizing information to improve standards of care.

II. PROCEDURES:

A quarterly review of the records of persons served will be conducted by the organization. The review will assess whether the following has been achieved in a quality manner:

1) Persons served were provided a complete orientation

2) Persons served were actively involved in making informed choices

3) Assessments were thorough, complete, and timely

4) Goals and objectives were based on the results of the assessments and the input of the person served

5) The services provided were related to the goals and objectives

6) Services were documented in accordance with the organization's policy

7) The individual plan is reviewed and updated

8) Other areas of care the organization deems important to quality service delivery.

The Utilization Manager, UM will be responsible for the general oversight of the quality record review process and will conduct the review process as follows:

1) The UM will randomly select open and closed records for review and assign each committee member a record or records to review.

2) The UM will be responsible for constructively reviewing cases according to the criteria, and safeguarding the confidentiality of the review process.

3) The quality record review process will utilize the Record Review Form to document the findings and structure the review process.

4) The Utilization Manager will review three files each quarter and complete the review form.

5) During the review process, open discussion among the UM and Quality and Compliance Officer will be encouraged to facilitate conceptualization of cases and practices, and to assist in clarification of the review measures.

6) All records involved in the quality record review process will be maintained confidentially as per the policies and procedures of the organization.

7) At the conclusion of the meeting, the UM will collect the review forms for all the records that were reviewed and return all records to their secured storage locations.

8) The individual results will only be shared with the clinical staff that was identified to be responsible for service coordination of an individual record. No clinician-specific information from the review process will be shared with staff and/or management personnel, other than the clinician's supervisor and/or reviewer of the record.

9) Clinical staff will be provided further feedback upon request and during individual supervisory sessions and annual performance reviews.

10) The aggregate results, as reported on the Quarterly Record Review Form, will be provided to clinical and management personnel at regular staff meetings to ensure that the results are being used to improve the organization's clinical practices and resulting outcomes.

11) Quarterly results will be tracked by clinical management staff to analyze trends and to judge the extent that interventions, based on the results, have improved the quality of care.

12) An annual Quality Records Review Summary will be distributed throughout the organization to increase awareness of strengths and areas of needed improvement in the area of quality and utilization of services.

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2568 Park Central Blvd
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March 20, 2020

Coronavirus (COVID-19) Response in Georgia

ACR Health Services is working closely with The Department of Human Resources, The Department of Juvenile Justice, The Department of Behavioral Health, surrounding metro Atlanta Juvenile courts, Child placement/foster care agencies, and other community partners to prepare for a potential outbreak of COVID-19 in Georgia. The goal is to prevent and reduce the transmission of the potential virus between ACR staff, other partnered agency staff, individuals being served, and their families, in addition to quickly identify cases of COVID-19 and take the appropriate public health action to reduce its spread and protect the general public.

ACR has responded to other serious disease outbreaks and each instance has provided new insight and guidance and highlighted the need to be as prepared as we can be. ACR is providing CDC information, monitoring, and guidance about COVID-19 to all staff, individuals, and caregivers and disseminating weekly information via verbal, electronic, and written -- communication to update information and answer questions. ACR has an on-call 24/7 crisis line at **678-499-8695** to assist staff, individuals, caregivers, referral sources, and the general public in the process to help support individuals presenting with symptoms of and/or concerns related to COVID-19 in the next steps to manage and/or identify risk factors/concerns as well as directing them to the CDC website for further information and current updates. https://www.cdc.gov/coronavirus/2019-ncov/index.html

Should it become necessary, ACR may recommend appropriate reduction of serious potential effect on communities, such as temporary closure of facility, workplace social distancing measures, and postponement or cancellation of mass gatherings. Additionally, ACR is implementing strategies to reduce the impact of a potential COVID-19 outbreak in the workforce, including teleworking, cross-training employees on essential job functions, and prevention, as well as treatment for and containment of COVID-19

The following measures are urged to prevent the spread of any respiratory viruses:

- If you, your child(ren), anyone in your home, or that you have had contact with in the last 24 hours, has the following symptoms: diarrhea, persistent coughing, fever, difficulty breathing, sore throat, and please contact the main office at 404-299-2087 to inform us of these symptoms in order to determine service delivery during this current heightened COVID-19 period.
- Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, use an alcohol-based hand sanitizer.

ACCOMPANYING INDIVIDUALS ON THEIR WELLNESS JOURNEY

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- Avoid touching your eyes, nose and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cough or sneeze into your elbow or use a tissue to cover it, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces.
- The best prevention against the flu is vaccination. Flu is still widespread and active in Georgia - it's not too late to get a flu shot.

Further, fear and anxiety about this disease has led to unnecessary stigma and discrimination against certain populations. It is important to remember that viruses cannot target people from specific populations, ethnicities or racial backgrounds.
For more about stigma related to COVID-19 and how to prevent it, please see https://www.cdc.gov/coronavirus/2019-ncov/about/related-stigma.html.

Read updated Centers for Disease Control (CDC) information about the virus, how it is spread, and how to protect yourself: https://www.cdc.gov/coronavirus/2019-ncov/about/index.html.

Read current Georgia Department Public Health guidance:
https://dph.georgia.gov/novelcoronavirus

Like in everything else we do in our profession, ACR's response to the COVID-19 Pandemic will be based on evidence-based practices. Remind mindful that the evidence-based practices for infection control and disease prevention/treatment come from the CDC and/or Nation Institute of Health. ACR will only share evidenced-based information with the individuals who participate in our programs.

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Infection Prevention Measures

All ACR staff members should implement good hygiene and infection control practices, including:

1. All employees will receive training on and follow the hand washing procedure recommended by the CDC which is summarized below:

Follow these five steps every time

- Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
- Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
- Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- Rinse your hands well under clean, running water.
- Dry your hands using a clean towel or air dry them.

2. **Use Hand Sanitizer When You Can't Use Soap and Water.** Sanitizers can quickly reduce the number of germs on hands in many situations. However,
   - Sanitizers do not get rid of all types of germs.
   - Hand sanitizers may not be as effective when hands are visibly dirty or greasy.
   - Hand sanitizers might not remove harmful chemicals from hands like pesticides and heavy metals.
3. **How to use hand sanitizer**
   - Apply the gel product to the palm of one hand (read the label to learn the correct amount).
   - Rub your hands together.
   - Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds.
4. Hand sanitizer containing at least 60% alcohol will be placed at a convenient location by all entry doors. All persons will apply hand sanitizer to their hands immediately upon entering into any ACR facility. Reception staff will remind all individuals to use hand sanitizer.
5. All staff members, visitors and clients entering past the lobby door will immediately go to a breakroom or restroom to wash their hands following the CDC recommended procedures.
6. Staff will frequently and thorough wash their hands for a least 20 seconds with soap and running water following the CDC recommended hand washing procedures. Hands will be washed after touching any common contact surface, like copy machines, printers, breakroom tables, microwave, restrooms, door knobs. Paper towels shall be used to turn faucets on and off and to flush toilets and urinals.
7. ACR employees will receive training on infection prevention and respiratory etiquette, including covering coughs and sneezes.

8. ACR's Safety Officer will identify the supplies, equipment and items needed by ACR and its staff for infection control, sources for the infection control items identified, maintain an accurate inventory of ACR infection control items and ensure that orders are placed to maintain an adequate stock of infection control items.
9. **Signs** will be posted at**:**
    a. All entry doors informing that hand sanitizer must be used before using the door knob or handle for entry. The sign will also explain the proper use of hand sanitizer.
    b. All sinks to explain the CDC's recommended hand washing procedure.
10. **COVID 19 Public Health Emergency Specific Requirements**
    a. Prior to entry into the office, all employees and approved visitors:
        i. Will have their temperature measured with a no touch thermometer.
        ii. In addition, their symptoms will be assessed utilizing the attached COVID-19 Screening Form.
    b. Anyone with the following symptoms will be denied entry beyond ACR's lobby and will not be allowed into the main office area.
        i. Been in contact with someone who has been diagnosed with COVID-19 or suspected of having COVID-19 in the last two (2) weeks.
        ii. Temperature above 100 degrees or higher will be denied entry into the office.
        iii. Fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat and/or new loss of taste or smell.
    c. ACR employees use the COVID-19 Screening Form and will self-report symptoms to their supervisor or Executive Director prior to leaving from home to work. If they are experiencing any of the above symptoms, they will self- quarantine and will be granted permission to work from home until their symptoms self-resolve or they are released by a physician to return to work. This rule also applies if anyone in their household has anyone of the above symptoms.
    d. Each administrative employee will endeavor to remain in their individual office with the door closed as possible with limited face to face contact with other staff members. During the course of the workday when it is necessary to engage with other staff members staff members the primary and preferred way will by telephone. Staff meetings will be held by using an internet meeting system. If a face to face conservation cannot be avoided, all staff members will wear a face mask, remain six (6) feet from each other and with no more than 3 staff members.
    e. Employees will wear a face mask upon entering the office from outside, the mask will remain on until the employee enters in their personal office and closes their office door.
    f. Face masks will be worn anytime employees are outside their personal office.

All ACR Leadership members will stay aware of CDC recommendations for infection prevention measures determine the applicably of implementation for ACR staff and ACR offices and facilities.

Policy 09.24 - Infectious Disease Vaccination

I. PURPOSE:

Consistent with our duty to provide and maintain an environment that is free of recognized hazards, Assertive Community Recovery, LLC d/b/a ACR Health Services ("ACR") has adopted a COVID-19 Vaccination Policy to safeguard the health and well-being of the individuals participating in ACR's behavioral health recovery programs, employees and their families, visitors and others who spend time in our facility, and the community from infectious conditions, such as COVID-19 or influenza, that may be mitigated through an effective vaccination program.

This policy will comply with all applicable laws and is based on guidance from the Centers for Disease Control and Prevention (CDC) and local health authorities, as applicable.

II. SCOPE:

All employees are required to receive vaccinations as determined by ACR's Leadership Team, unless a reasonable accommodation is approved. Employees not in compliance with this policy will be placed on unpaid leave until their employment status is determined by the human resources department.

II. POLICY:

A. Employees will be notified by the human resources department as to the type of vaccination(s) covered by this policy and the timeframe(s) for having the vaccine(s) administered. ACR Health Services will provide either onsite access to the vaccines or a list of locations to assist employees in receiving the vaccine on their own.
B. ACR Health Services will pay for all vaccinations. When not received in-house, vaccinations should be run through employees' health insurance where applicable and otherwise be submitted for reimbursement.
C. Before the stated deadlines to be vaccinated have expired, employees will be required to provide either proof of vaccination or an approved reasonable accommodation to be exempted from the requirements.

III. Requests for Exemptions as Accommodations:

A. To assist any employee who is disabled, who is pregnant, who is a nursing mother, who has a qualifying medical condition that contraindicates the vaccination, or who objects to being vaccinated on the basis of sincerely held religious beliefs and practices, ACR will engage in an interactive process to determine if a reasonable accommodation can be provided so long as it does not create an undue hardship for ACR and/or does not pose a direct threat to the health or safety of others in the workplace and/or to the employee.
B. To request an accommodation for one of the above reasons, please notify the Quality Assurance and Compliance Director in writing at THarris@ACRHealthGA.com.
C. Once ACR is aware of the need for an accommodation, ACR will engage in an interactive process to identify possible accommodations.

D. If you believe that you have been treated in a manner not in accordance with this policy, please notify ACR immediately by speaking to the Quality Assurance and Compliance Director.
E. You may request an accommodation without fear of retaliation.

Office: 404 508-0078 Fax 404 508-0071
email: employment@ACRHealthGA.com

2568 PARK CENTRAL BLVD
DECATUR, GA 30035-3916

July 19, 2021

All ACR Staff Members

COVID-19 Vaccinations

1. All ACR staff members are required to show proof of a COVID-19 vaccination no later than August 30, 2021. In the case of a two-dose vaccination, such as the Pfizer-BioNTech and Moderna vaccines, the proof of the first dose must be provided by August 30, 2021 and the proof of the second dose must be presented by September 30, 2021.

2. Requests for Exemptions as an Accommodation in accordance with ACR Policy 09.24 - Infectious Disease Vaccination must be submitted by August 15, 2021.

3. Currently, there are some jobs that can be done completely remotely and by telehealth. This vaccination requirement will not apply to individuals performing in those roles.

4. After September 30, 2021, no employees without a full COVID-19 vaccination will be allowed in any ACR facility. Work performed by staff members who are not vaccinated will be performed completely by telehealth or remotely.

5. Effective immediately, face-to-face services with program participants and/or their families will be only be provided by fully vaccinated staff. Any staff member who is not fully vaccinated will only provide services via telehealth or while all parties are wearing a face mask, outdoors and remaining at least six-feet apart.

Sincerely,

Frank S. McAllister
CEO
ACR Health Services

Office: 404 508-0078 Fax 404 508-0071
email: Employment@ACRHealthGA.com

2568 Park Central Blvd
Decatur, GA 30035

COVID-19 SCREENING FORM

TYPE OF CONTACT	(CIRCLE ONE): **FACE TO FACE** **OR** **PHONE**	
DATE		
NAME OF PERSON SCREENED	First	Last
ADDRESS	# STREET	
	CITY	
	ZIP CODE	
PHONE NUMBER	( )	

#	COVID-19 SCREENING QUESTIONS (Circle Yes or No)				
1	Have you been exposed to anyone that has diagnosed or suspected to have been diagnosed in last two(2) weeks?			**Yes**	**No**
2	Have you flu like symptoms in last (2) weeks?			**Yes**	**No**
3	**Do you have any of the following?**				
	Fever	**Yes** **No**	Muscle pain	**Yes**	**No**
	Cough	**Yes** **No**	Headache	**Yes**	**No**
	Shortness of breath or difficulty breathing	**Yes** **No**	Sore throat	**Yes**	**No**
	Chills	**Yes** **No**	New loss of taste or smell	**Yes**	**No**
	Repeated shaking with chills	**Yes** **No**			
4	**Measured Temperature _____**	**Is Measured Temperature above 100 degrees**		**Yes**	**No**

IF ANY ANSWERS WERE 'YES', YOU ARE REQUIRED TO COMPLETE THIS INFORMATION:		
NAME OF PERSON SCREENED	**ADDRESS**	**BEST CONTACT NUMBER**
	# Street	
	City	
	Zip	

Covid-19 Screening Form Instructions:

1. All Staff, Guests, Individuals, Caregivers, Contractors, Service Reps, and anyone seeking access to office or coming in contact within the community MUST have form completed.
2. Additionally, this form MUST be completed prior to scheduling any face-to-face contact / visits with individuals.
3. Visits with consumers/families MUST adhere to social distancing (maintaining a distance of 6ft or more, no touching)
4. Visits with individuals/families MUST adhere to preventative measures to spread such as: washing hands, avoid people who are sick, stay at home if you are sick, avoid touching eyes/nose/mouth with unwashed hands, and/or if experiencing flu like symptoms.
5. Submit FULLY completed form within 24 hours.

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Clean & Disinfect

Interim Recommendations for US Households with Suspected/Confirmed Coronavirus Disease 2019

Background

There is much to learn about the novel coronavirus that causes coronavirus disease 2019 (COVID-19). Based on what is currently known about the novel coronavirus and similar coronaviruses that cause SARS and MERS, spread from person-to-person with these viruses happens most frequently among close contacts (within about 6 feet). This type of transmission occurs via respiratory droplets. On the other hand, transmission of novel coronavirus to persons from surfaces contaminated with the virus has not been documented. Transmission of coronavirus occurs much more commonly through respiratory droplets than through fomites. Current evidence suggests that novel coronavirus may remain viable for hours to days on surfaces made from a variety of materials. Cleaning of visibly dirty surfaces followed by disinfection is a best practice measure for prevention of COVID-19 and other viral respiratory illnesses in households and community settings.

Purpose

This guidance provides recommendations on the cleaning and disinfection of households where persons under investigation (PUI) or those with confirmed COVID-19 reside or may be in self-isolation. It is aimed at limiting the survival of the virus in the environments. These recommendations will be updated if additional information becomes available.

These guidelines are focused on household settings and are meant for the general public.

- **Cleaning** refers to the removal of germs, dirt, and impurities from surfaces. Cleaning does not kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.
- **Disinfecting** refers to using chemicals to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface *after* cleaning, it can further lower the risk of spreading infection.

General Recommendations for Routine Cleaning and Disinfection of Households

Community members can practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks) with household cleaners and EPA-registered disinfectants that are appropriate for the surface, following label instructions. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves and making sure you have good ventilation during use of the product.

General Recommendations for Cleaning and Disinfection of Households with People Isolated in Home Care (e.g. Suspected/Confirmed to have COVID-19)

- Household members should educate themselves about COVID-19 symptoms and preventing the spread of COVID-19 in homes.
- **Clean and disinfect high-touch surfaces daily in household common areas (e.g. tables, hard-backed chairs, doorknobs, light switches, remotes, handles, desks, toilets, sinks)**
  - In the bedroom/bathroom dedicated for an ill person: consider reducing cleaning frequency to **as-needed** (e.g., soiled items and surfaces) to avoid unnecessary contact with the ill person.
    - As much as possible, an ill person should stay in a specific room and away from other people in their home, following home care guidance.
    - The caregiver can provide personal cleaning supplies for an ill person's room and bathroom, unless the room is occupied by child or another person for whom such supplies would not be appropriate. These supplies include tissues, paper towels, cleaners and EPA-registered disinfectants (examples at this link).
    - If a separate bathroom is not available, the bathroom should be cleaned and disinfected after each use by an ill person. If this is not possible, the caregiver should wait as long as practical after use by an ill person to clean and disinfect the high-touch surfaces.
- Household members should follow home care guidance when interacting with persons with suspected/confirmed COVID-19 and their isolation rooms/bathrooms.

How to clean and disinfect:

Surfaces

- Wear disposable gloves when cleaning and disinfecting surfaces. Gloves should be discarded after each cleaning. If reusable gloves are used, those gloves should be dedicated for cleaning and disinfection of surfaces for COVID-19 and should not be used for other purposes. Consult the manufacturer's instructions for cleaning and disinfection products used. Clean hands immediately after gloves are removed.
- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, diluted household bleach solutions, alcohol solutions with at least 70% alcohol, and most common EPA-registered household disinfectants should be effective.
  - Diluted household bleach solutions can be used if appropriate for the surface. Follow manufacturer's instructions for application and proper ventilation. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.
    - Prepare a bleach solution by mixing:
      - 5 tablespoons (1/3rd cup) bleach per gallon of water or
      - 4 teaspoons bleach per quart of water
  - Products with EPA-approved emerging viral pathogens claims are expected to be effective against COVID-19 based on data for harder to kill viruses. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely, or
    Use products with the EPA-approved emerging viral pathogens claims (examples at this link) that are suitable for porous surfaces.

Clothing, towels, linens and other items that go in the laundry

- Wear disposable gloves when handling dirty laundry from an ill person and then discard after each use. If using reusable gloves, those gloves should be dedicated for cleaning and disinfection of surfaces for COVID-19 and should not be used for other household purposes. Clean hands immediately after gloves are removed.
  - If no gloves are used when handling dirty laundry, be sure to wash hands afterwards.
  - If possible, do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry from an ill person can be washed with other people's items.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If possible, consider placing a bag liner that is either disposable (can be thrown away) or can be laundered.

Hand hygiene and other preventive measures

- Household members should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Household members should follow normal preventive actions while at work and home including recommended hand hygiene and avoiding touching eyes, nose, or mouth with unwashed hands.
  - Additional key times to clean hands include:
    - After blowing one's nose, coughing, or sneezing
    - After using the restroom
    - Before eating or preparing food
    - After contact with animals or pets
    - Before and after providing routine care for another person who needs assistance (e.g. a child)

Other considerations

- The ill person should eat/be fed in their room if possible. Non-disposable food service items used should be handled with gloves and washed with hot water or in a dishwasher. Clean hands after handling used food service items.
- If possible, dedicate a lined trash can for the ill person. Use gloves when removing garbage bags, handling, and disposing of trash. Wash hands after handling or disposing of trash.
- Consider consulting with your local health department about trash disposal guidance if available.

Additional Resources

- OSHA COVID-19 Website
- CDC Home Care Guidance

Page last reviewed: March 6, 2020

Interim Public Health Recommendations for Fully Vaccinated People

Updated July 27, 2021 Print

Summary of Recent Changes

Updates as of July 27, 2021

- Updated information for fully vaccinated people given new evidence on the B.1.617.2 (Delta) variant currently circulating in the United States.
- Added a recommendation for fully vaccinated people to wear a mask in public indoor settings in areas of substantial or high transmission.
- Added information that fully vaccinated people might choose to wear a mask regardless of the level of transmission, particularly if they are immunocompromised or at increased risk for severe disease from COVID-19, or if they have someone in their household who is immunocompromised, at increased risk of severe disease or not fully vaccinated.
- Added a recommendation for fully vaccinated people who have a known exposure to someone with suspected or confirmed COVID-19 to be tested 3-5 days after exposure, and to wear a mask in public indoor settings for 14 days or until they receive a negative test result.
- CDC recommends universal indoor masking for all teachers, staff, students, and visitors to schools, regardless of vaccination status

View Previous Updates

Key Points

The following recommendations apply to non-healthcare settings. For related information for healthcare settings, visit Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.

Fully vaccinated people can:

- Participate in many of the activities that they did before the pandemic; for some of these activities, they may choose to wear a mask.
- Resume domestic travel and refrain from testing before or after travel and from self-quarantine after travel
- Refrain from testing before leaving the United States for international travel (unless required by the destination) and refrain from self-quarantine after arriving back in the United States
- Refrain from testing following a known exposure, if asymptomatic, with some exceptions for specific settings
- Refrain from quarantine following a known exposure if asymptomatic
- Refrain from routine screening testing if feasible

Infections happen in only a small proportion of people who are fully vaccinated, even with the Delta variant. However, preliminary evidence suggests that fully vaccinated people who do become infected with the Delta variant can spread the virus to others. To reduce their risk of becoming infected with the Delta variant and potentially spreading it to others: CDC recommends that fully vaccinated people:

- Wear a mask in public indoor settings if they are in an area of substantial or high transmission,

    - Fully vaccinated people might choose to mask regardless of the level of transmission, particularly if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is unvaccinated. People who are at increased risk for severe disease include older adults and those who have certain medical conditions, such as diabetes, overweight or obesity, and heart conditions.
- Get tested if experiencing COVID-19 symptoms.
- Get tested 3-5 days following a known exposure to someone with suspected or confirmed COVID-19 and wear a mask in public indoor settings for 14 days after exposure or until a negative test result.
- Isolate if they have tested positive for COVID-19 in the prior 10 days or are experiencing COVID-19 symptoms.
- Follow any applicable federal, state, local, tribal, or territorial laws, rules, and regulations.

People who are immunocompromised should be counseled about the potential for reduced immune responses to COVID-19 vaccines and to follow current prevention measures (including wearing a mask, staying 6 feet apart from others they don't live with, and avoiding crowds and poorly ventilated indoor spaces) regardless of their vaccination status to protect themselves against COVID-19 until advised otherwise by their healthcare provider.

Overview

Currently authorized vaccines in the United States are highly effective at protecting vaccinated people against symptomatic and severe COVID-19. Fully vaccinated people are less likely to become infected and, if infected, to develop symptoms of COVID-19. They are at substantially reduced risk of severe illness and death from COVID-19 compared with unvaccinated people.

Infections in fully vaccinated people (breakthrough infections) happen in only a small proportion of people who are fully vaccinated, even with the Delta variant. Moreover, when these infections occur among vaccinated people, they tend to be mild. However, preliminary evidence suggests that fully vaccinated people who do become infected with the Delta variant can be infectious and can spread the virus to others.

For the purposes of this guidance, people are considered fully vaccinated for COVID-19 ≥2 weeks after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or ≥2 weeks after they have received a single-dose vaccine (Johnson & Johnson [J&J]/Janssen)†. There is currently no post-vaccination time limit on fully vaccinated status. People are considered not fully vaccinated if they have not completed a two-dose vaccination series or have not received a single-dose vaccine, regardless of age, including children under the age of 12.

Data suggest immune response to COVID-19 vaccination might be reduced in some immunocompromised people including, but not limited to, people receiving chemotherapy for cancer, people with hematologic cancers such as chronic lymphocytic leukemia, people receiving stem cells or organ transplants, people receiving hemodialysis, and people using certain medications that might blunt the immune response to vaccination (e.g., mycophenolate, rituximab, azathioprine, anti-CD20 monoclonal antibodies, Bruton tyrosine kinase inhibitors).

People who are immunocompromised should be counseled about the potential for reduced immune responses to COVID-19 vaccines and the need to continue to follow current prevention measures (including wearing a mask, staying 6 feet apart from others they don't live with, and avoiding crowds and poorly ventilated indoor spaces) to protect themselves against COVID-19 until advised otherwise by their healthcare provider. Close contacts of immunocompromised people should also be encouraged to be vaccinated against COVID-19 to help protect these people.

This guidance provides recommendations for fully vaccinated people, including:

- How fully vaccinated people can safely resume many activities while protecting others
- How fully vaccinated people should approach domestic and international travel
- How fully vaccinated people should approach isolation, quarantine, and testing

CDC will continue to evaluate and update public health recommendations for fully vaccinated people as more information, including on Delta and other new variants, becomes available. Further information on evidence and considerations related to these recommendations is available in the Science Brief.

Guiding Principles for Fully Vaccinated People

- Outdoor activities pose minimal risk to fully vaccinated people.
- Most indoor activities pose low risk to fully vaccinated people, especially in areas with low or moderate transmission.
- Infections happen in only a small proportion of people who are fully vaccinated, even with the Delta variant.

- Fully vaccinated people who become infected with the Delta variant can transmit it to others.

To reduce their risk of becoming infected with the Delta variant and potentially spreading it to others, CDC recommends that fully vaccinated people:

- Wear a mask in public indoor settings if they are in an area of substantial or high transmission,
  - Fully vaccinated people might choose to mask regardless of the level of transmission, particularly if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is unvaccinated.
- Get tested if experiencing COVID-19 symptoms.
- Isolate if they have tested positive for COVID-19 in the prior 10 days or are experiencing COVID-19 symptoms.
- Get tested 3-5 days after exposure to someone with suspected or confirmed COVID-19 and wear a mask in public indoor settings for 14 days after exposure or until they receive a negative test result.
- Continue to follow any applicable federal, state, local, tribal, or territorial laws, rules, and regulations.

Recommendations for Indoor Settings

Risk of SARS-CoV-2 infection, severe disease, and death is reduced for fully vaccinated people. Though they happen in only a small proportion of people who are fully vaccinated, some infections do occur among fully vaccinated people. Fully vaccinated people who do become infected with the Delta variant can transmit it to others. Therefore, fully vaccinated people can further reduce their risk of becoming infected with the Delta variant and transmitting it to others by wearing a mask in public indoor settings in areas of substantial or high community transmission. Wearing a mask in public is most important for people who are immunocompromised. Fully vaccinated people might choose to mask regardless of the level of transmission, particularly if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is unvaccinated. People at increased risk for severe disease includes older adults and those who have certain medical conditions, such as diabetes, overweight or obesity, and heart conditions. Members of the household who are unvaccinated include any adults who have not completed vaccination, who cannot be vaccinated, and those who are not eligible for vaccines, including children less than 12 years of age. Fully vaccinated people should also continue to wear a mask where required by federal, state, local, tribal, or territorial laws, rules, and regulations, including local business and workplace guidance, and in correctional facilities and homeless shelters. Prevention measures are still recommended for unvaccinated people.

CDC recommends universal indoor masking for all teachers, staff, students, and visitors to schools, regardless of vaccination status. Children should return to full-time in-person learning in the fall with proper prevention strategies in place.

Recommendations for Outdoor Settings

Current data suggest the risk of transmission of SARS-CoV-2 in outdoor settings is minimal. In general, fully vaccinated people do not need to wear a mask outdoors. Fully vaccinated people might choose to wear a mask in crowded outdoor settings if they or someone in their household is immunocompromised.

Travel

Fully vaccinated travelers are less likely to get and spread SARS-CoV-2 and can now travel at low risk to themselves within the United States. International travelers need to pay close attention to the situation at their international destinations before traveling due to the spread of new variants and because the burden of COVID-19 varies globally.

Wearing a mask over your nose and mouth is required on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and while indoors at U.S. transportation hubs such as airports and stations. Travelers are not required to wear a mask in outdoor areas of a conveyance (like on open deck areas of a ferry or the uncovered top deck of a bus).

Domestic travel (within the United States or to a U.S. territory)

- Fully vaccinated travelers do not need to get a SARS-CoV-2 viral test before or after domestic travel, unless testing is required by local, state, or territorial health authorities.
- Fully vaccinated travelers do not need to self-quarantine following domestic travel.
- For more information, see Domestic Travel During COVID-19.

International travel

- Fully vaccinated travelers do not need to get tested before leaving the United States unless required by their destination

- Fully vaccinated air travelers coming to the United States from abroad, including U.S. citizens, are still required to have a negative SARS-CoV-2 viral test result or documentation of recovery from COVID-19 before they board a flight to the United States.
- International travelers arriving in the United States are still recommended to get a SARS-CoV-2 viral test 3-5 days after travel regardless of vaccination status.
- Fully vaccinated travelers do not need to self-quarantine in the United States following international travel.
- For more information, see International Travel During COVID-19.

Recommendations for Isolation, Quarantine and Testing

The following recommendations apply to non-healthcare settings. Guidance for residents and staff of healthcare settings can be found in the Updated Healthcare Infection Prevention Control Recommendations in Response to COVID-19 Vaccination.

Fully vaccinated people with COVID-19 symptoms

Although the risk that fully vaccinated people could become infected with COVID-19 is low, any fully vaccinated person who experiences symptoms consistent with COVID-19 should isolate themselves from others, be clinically evaluated for COVID-19, and tested for SARS-CoV-2 if indicated. The symptomatic fully vaccinated person should inform their healthcare provider of their vaccination status at the time of presentation to care.

Fully vaccinated people with no COVID-like symptoms following an exposure to someone with suspected or confirmed COVID-19

Most fully vaccinated people with no COVID-like symptoms do not need to quarantine, be restricted from work, or be tested following an exposure to someone with suspected or confirmed COVID-19, as their risk of infection is low.

However, they should still monitor for symptoms of COVID-19 for 14 days following an exposure.

Exceptions where testing (but not quarantine) is still recommended following an exposure to someone with suspected or confirmed COVID-19 include:

- Fully vaccinated residents and employees of correctional and detention facilities and homeless shelters.

Fully vaccinated people with no COVID-19-like symptoms and no known exposure to someone with suspected or confirmed COVID-19

Fully vaccinated people should be tested 3-5 days following a known exposure to someone with suspected or confirmed COVID-19 and wear a mask in public indoor settings for 14 days or until they receive a negative test result, and isolate if they test positive. Fully vaccinated people who live in a household with someone who is immunosuppressed, at increased risk of severe disease, or unvaccinated (including children <12 years of age) could also consider masking at home for 14 days following a known exposure or until they receive a negative test result. Most fully vaccinated people with no COVID-like symptoms do not need to quarantine or be restricted from work following an exposure to someone with suspected or confirmed COVID-19 if they wear a mask in public indoor settings for 14 days after exposure or if they receive a negative test result from a test taken 3-5 days after exposure. They should isolate if they test positive.

For Healthcare Professionals

COVID-19 Clinical Resources

†This guidance applies to COVID-19 vaccines currently authorized for emergency use by the U.S. Food and Drug Administration: Pfizer-BioNTech, Moderna, and Johnson & Johnson (J&J)/Janssen COVID-19 vaccines. This guidance can also be applied to COVID-19 vaccines that have been authorized for emergency use by the World Health Organization (e.g. AstraZeneca/Oxford).

Previous Updates

Updates from Previous Content

As of July 16, 2021

- Updated considerations for people who are immunocompromised

As of July 12, 2021

- Updated Choosing Safer Activities infographic with new considerations for the example activity for outdoor gatherings with fully vaccinated and unvaccinated people.

As of May 13, 2021

- Update that fully vaccinated people no longer need to wear a mask or physically distance in any setting, except where required by federal, state, local, tribal, or territorial laws, rules, and regulations, including local business and workplace guidance
- Update that fully vaccinated people can refrain from testing following a known exposure unless they are residents or employees of a correctional or detention facility or a homeless shelter

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Last Updated July 27, 2021

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19)

The true impact of a COVID-19 outbreak in a U.S. community cannot be predicted. However, all healthcare facilities can take steps now to prepare for such an outbreak and protect both their patients and staff.

Be prepared:

- **Stay informed about the local COVID-19 situation.** Know where to turn for reliable, up-to-date information in your local community. Monitor the CDC COVID-19 website and your state and local health department websites for the latest information.
- **Develop, or review, your facility's emergency plan.** A COVID-19 outbreak in your community could lead to staff absenteeism. Prepare alternative staffing plans to ensure as many of your facility's staff are available as possible.
- **Establish relationships with key healthcare and public health partners in your community.** Make sure you know about healthcare and public health emergency planning and response activities in your community. Learn about plans to manage patients, accept transfers, and share supplies. Review any memoranda of understanding (MOUs) with affiliates, your healthcare coalition, and other partners to provide support or assistance during emergencies.
- **Create an emergency contact list**. Develop and continuously update emergency contact lists for key partners and ensure the lists are accessible in key locations in your facility. For example, know how to reach your local or state health department in an emergency.

Communicate with staff and patients:

- **Communicate about COVID-19 with your staff.** Share information about what is currently known about COVID-19, the potential for surge, and your facility's preparedness plans.
- **Communicate about COVID-19 with your patients.** Provide updates about changes to your policies regarding appointments, providing non-urgent patient care by telephone, and visitors. Consider using your facility's website or social media pages to share updates.

Protect your workforce:

- **Screen patients and visitors for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering your healthcare facility.** Keep up to date on the recommendations for preventing spread of COVID-19 on CDC's website.
- **Ensure proper use of personal protection equipment (PPE).** Healthcare personnel who come in close contact with confirmed or possible patients with COVID-19 should wear the appropriate personal protective equipment.
- **Conduct an inventory of available PPE.** Consider conducting an inventory of available PPE supplies. Explore strategies to optimize PPE supplies.
- **Encourage sick employees to stay home.** Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. Ensure that your sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Protect your patients:

- **Stay up-to-date** on the best ways to manage patients with COVID-19.
- **Separate patients with respiratory symptoms so they are not waiting among other patients seeking care.** Identify a separate, well-ventilated space that allows waiting patients and visitors to be separated.
- **Consider the strategies to prevent patients who can be cared for at home from coming to your facility potentially exposing themselves or others to germs, like**:
  - Using your telephone system to deliver messages to incoming callers about when to seek medical care at your facility, when to seek emergency care, and where to go for information about caring for a person with COVID at home

- Adjusting your hours of operation to include telephone triage and follow-up of patients during a community outbreak.
- Leveraging telemedicine technologies and self-assessment tools.

Page last reviewed: March 6, 2020

DO choose masks that

Have two or more layers of washable, breathable fabric

Completely cover your nose and mouth

Fit snugly against the sides of your face and don't have gaps

Have a nose wire to prevent air from leaking out of the top of the mask

DO NOT choose masks that

Are made of fabric that makes it hard to breathe, for example, vinyl

Have exhalation valves or vents, which allow virus particles to escape

Are intended for healthcare workers, including N95 respirators

cdc.gov/coronavirus

CS 319876-O April 28, 2021 8:45 AM

Get vaccinated.
Get your smartphone.
Get started with v-safe.

Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.

Sign up with your smartphone's browser at

vsafe.cdc.gov

OR

Aim your smartphone's camera at this code

Learn more about ***v-safe*** www.cdc.gov/vsafe

CS324195-C 04/27/2021

Get vaccinated.
Get your smartphone.
Get started with v-safe.

Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.

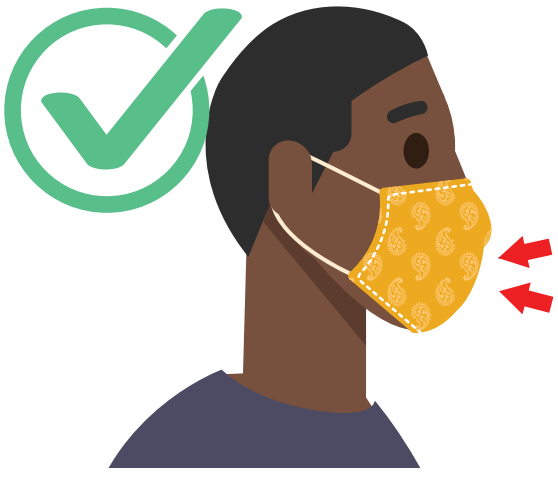
When you get your COVID-19 vaccination, ask your healthcare provider about getting started with v-safe

Learn more about **v-safe**
www.cdc.gov/vsafe

CS324195-B 04/27/2021

DO choose masks that

Have two or more layers of washable, breathable fabric



Completely cover your nose and mouth

Fit snugly against the sides of your face and don't have gaps

Have a nose wire to prevent air from leaking out of the top of the mask

cdc.gov/coronavirus

CS 319876-O April 27, 2021 3:19 PM

Print in color on 3.5" W x 5.0" H self-adhesive labels or plain paper

BIOHAZARD

PELIGRO WARNING

ALTERNATIVE SHARPS CONTAINER

NOT AN FDA-CLEARED SHARPS DISPOSAL CONTAINER

FOR CONTAMINATED SHARPS ONLY
(e.g., needle, syringe, scalpel)

Label produced by the U.S. Department of Health and Human Services, Centers for Disease Control and Preventio
This label does not create new or additional OSHA requirements.

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CS32105-A

What do I need to know about
Johnson & Johnson's Janssen COVID-19 Vaccine (J&J/Janssen) now?

There is a risk of a rare but serious condition involving blood clots and low platelets in people after receiving the J&J/Janssen COVID-19 Vaccine. **This risk is very low.**

This problem is rare and happened in about 7 per 1 million vaccinated women between 18 and 49 years old.

For women 50 years and older and men of any age, this problem is even more rare.

This problem has not been linked to the other two COVID-19 vaccines (Pfizer-BioNTech and Moderna).

SHOULD I STILL GET VACCINATED with this or other vaccines to protect against COVID-19?

YES, experts agree that all COVID-19 vaccines help prevent COVID-19 disease, especially severe illness and death.

The known and potential benefits of all COVID-19 vaccines outweigh the known and potential risks. You need only one dose of the J&J/Janssen vaccine. You need two doses of the other two vaccines (Pfizer-BioNTech and Moderna).

What if I already got the J&J/Janssen COVID-19 Vaccine?

For three weeks after getting the J&J/Janssen vaccine, you should watch for possible symptoms of a blood clot with low platelets, like:

- Severe headache or blurred vision
- Shortness of breath
- Chest pain
- Leg swelling
- Gut pain that does not go away
- Easy bruising or tiny blood spots under the skin

Get medical care right away if you develop any of these symptoms.

Learn more by talking with your doctor, nurse, or pharmacist, or visit the CDC website: **www.cdc.gov.**

cdc.gov/coronavirus

CS324167-A | April 28, 2021 11:56 AM