July 22, 2013

Dear Colleagues:

Enclosed are the Community Hospital Integration Projects Program (CHIPP) Guidelines. The Office of Mental Health and Substance Abuse Services (OMHSAS) remains committed to developing a consumer-driven, recovery-oriented mental health service system by continuing to reduce the use of state psychiatric inpatient services. CHIPP funds support individuals discharged from state hospitals by creating community-based services and supports. Counties receiving an annual allocation for CHIPP funding, as a categorical or as part of their Human Services Block Grant, are required to comply with these guidelines, which replace the CHIPP guidelines issued in 1999.

Please contact Valerie Vicari at vavicari@pa.gov, with any questions regarding the CHIPP Guidelines. Thank you for your continued partnership.

Sincerely,

Dennis Marion
Deputy Secretary
Community Hospital Integration Projects Program
(CHIPP) Guidelines

Office of Mental Health and Substance Abuse Services
Department of Public Welfare
Commonwealth of Pennsylvania

Issued: July 2013
SECTION I: BACKGROUND

Office of Mental Health and Substance Abuse Services (OMHSAS) continues to prioritize the availability of Community Hospital Integration Projects Program (CHIPP) funds to support selected discharges of individuals from state hospitals. All counties receiving an annual allocation for CHIPP funding, either as a categorical or as part of their Human Services Block Grant, are required to comply with allocation guidelines outlined in this document. These guidelines reflect improvements to this funding allocation process since 1979 and replace the CHIPP guidelines issued in 1999.

OMHSAS has a long history of implementing initiatives to reduce the use of state psychiatric inpatient services by creating services and supports that allow people with a serious mental illness to live in their community. The Commonwealth’s efforts began in 1979 with the closure of Hollidaysburg State Hospital.

Beginning in FY 1991, a financing strategy to promote continued reduction of state hospital utilization was formalized. The CHIPP provided funding to discharge hospitalized individuals into the community and reduce state hospital bed utilization. Allocation requirements for CHIPP funds were issued in March 1999 by OMHSAS. In that same year (1999) the Supreme Court’s Olmstead v. L.C. decision affirmed the rights of people who have a disability to live in community settings.

OMHSAS has closed 15 hospitals since July 1976. In 1976, these 15 hospitals had a combined census of over 6,000 beds. At the time of the issuance of this document in 2013, the total capacity of the remaining six state hospitals and one nursing care facility is approximately 1500 beds. Also, in 2012, 10% of all mental health funds were spent to support the state psychiatric hospital system, with 90 percent spent in community treatment services and supports.

SECTION II: OVERVIEW OF THE CHIPP ALLOCATION PROCESS

The CHIPP proposal includes a projected budget by cost center for two state fiscal years. First year funding is ordinarily half year start-up funds, with full annualization provided in the second year unless otherwise specified by OMHSAS. Funding usually begins in the second or third quarter of the following fiscal year, through a community mental health supplemental allocation. OMHSAS requires the use of the Consumer Support Planning (CSP) process for all individuals discharged that will utilize the CHIPP funding. A plan must be completed for each individual and funding requests must be aligned with the individual’s CSPs.

Final approval for a CHIPP allocation is documented in a Letter of Agreement (see Section VI. d)). The ongoing CSP process should continue and counties should solidify the ongoing coordination with the state hospital, individuals, families, and providers to complete the Consumer Support Plans (CSPs), individually planning for and developing the services and supports identified as needed by each person in the community.

Service development and discharge of CHIPP individuals must be accomplished by June 30th of the first fiscal year the CHIPP is funded. The CHIPP is monitored on an
ongoing basis by the county program to ensure that all people placed receive the level of treatment and support needed. OMHSAS, through the county oversight and reporting, monitors all CHIPP placements and expenditures. The county establishes a process to manage state hospital utilization within the annual bed target established in the CHIPP agreement among all the counties served by the hospital. Continuity of Care Committee (COC) monitors hospital use and the timeliness of admissions and discharges at COC meetings. The county remains responsible, on an ongoing basis, to actively assess how individuals discharged are doing and to ensure that needed services are being provided. The CHIPP statewide data base is updated annually to reflect the current status of all persons discharged with CHIPP funding.

SECTION III: TARGET POPULATION AND ASSESSMENT OF SERVICE NEEDS

Counties conduct reviews of all currently hospitalized individuals to determine which individuals would most benefit from CHIPP. When evaluating individuals for inclusion in the CHIPP, highest priority should be given to people with a long-term history of hospitalization, (i.e., over two years); persons with multiple hospitalizations, and people with otherwise complex service needs and/or dual diagnosis who have been unable to be successfully supported in the community. The process for assessing need is to be guided by the completion of a CSP. Assessment will include physical health and high risk medical needs for coordination with the Medical Assistance fee-for-service and HealthChoices physical health programs. Individuals should be assessed to determine if they qualify for DPW Home and Community Based waiver services for persons with an intellectual disability, adult autism, traumatic brain injury, etc.

The county and the state hospital will establish a mutually agreed upon list of individuals to be considered for discharge using the CSP process. This list will be based on the number of hospital beds targeted for closure and consistent with the characteristics of the target population. No person should be discharged if adequate community services required from the CSP are not in place or if the person’s discharge readiness status has significantly changed.

Identification of an Alternate (Non-Original) CHIPP Funded Individual

A new individual should be identified for all CHIPP participants who:

- are deceased;
- are hospitalized, incarcerated or placed in a nursing home for longer than six months (except as noted above);
- have moved out of the area or to another state;
- actively refuse to accept CHIPP funded services and choose to terminate contact for at least six months;
- choose to abruptly terminate contact and whose whereabouts are unknown; or
- are no longer receiving CHIPP funded services and are not known to be in any of the above categories.

Once a new individual has been identified, the originally named CHIPP participant will remain in HCSIS, coded as inactive, but will no longer be tracked with
annually updated data. When a CHIPP individual is made inactive, the first priority would be to identify a individual in the state hospital who has been there over two years and who requires significant supports in order to transition to the community. The costs associated with community-based services for this newly identified CHIPP recipient would be offset by the elimination of costs associated with the prior recipient. In some cases, the prior CHIPP individual had already been stepped down substantially from the intensive services and minimal funding becomes available. In those cases, it is permissible to identify a person in the community who was not previously identified as a CHIPP individual but who receives intensive services to prevent hospitalization. Typically, these individuals are accessing services that had been funded as CHIPP diversion services and would meet the criteria for a CHIPP individual.

If, at the time of the replacement, the individual is receiving minimal services, it is permissible to identify an individual in the community who meets the CHIPP criteria and who is receiving a high level of community services that are already funded through the availability of CHIPP funds. Identification of an alternate is the responsibility of the county. In this instance, counties should collaborate with the OMHSAS Regional Field Office and the Hospital CEO. Additional discussion will be required if OMHSAS does not believe the recommended individual meets the criteria outlined above. This new policy for identifying new CHIPP individuals has been effective January 1, 2011.

A CHIPP participant who is expected to be hospitalized, incarcerated, or in a nursing home for less than six months will maintain his/her status as a CHIPP participant. It may be reasonable to extend CHIPP status beyond six months based on an individual’s circumstances. The county will continue to be actively engaged with the individual and will seek to return them to the community in as short a time as possible. Documentation of contacts should be kept in the individual’s service record. During this period, the individual should be maintained in the Home and Community Service Information System (HCSIS) and the county should continue to have ongoing contact to ensure the person is receiving needed services and supports. If a CHIPP participant refuses to participate in services or their whereabouts are unknown, the county should continue to try to actively engage the individual and/or try to locate the individual, particularly if there is concern that without treatment the individual may become a danger to themselves or others. Documentation of these efforts should be kept in the individual’s service record.

SECTION IV: IMPACT OF JIMMIE LITIGATION ON CHIPP PROCESS

A settlement to the Jimmie litigation was reached on July 30, 2010 which called for the discharge planning of class members (persons with mental health and intellectual disabilities in state psychiatric hospitals) from the state hospitals over the course of three fiscal years (2010-11, 2011-12, and 2012-13). Each of the state mental hospitals identified class members who were to be discharged through the settlement agreement. A total of 75 class members were identified, all but nine of the individuals had been discharged by June 30, 2013. A Memorandum of Understanding was signed between OMHSAS and the Office of Developmental Programs (ODP) which agrees to the transfer of $140,000 from the OMHSAS budget to the ODP budget for each bed closed in order to support community services for each class member. Tracking of the success of the placement is primarily the responsibility of ODP, but OMHSAS continues
to partner in supporting the individuals in their community placements. A majority of these individuals have ongoing mental health supports through OMHSAS programs that supplement the ODP waiver services.

**SECTION V: PROGRAM REQUIREMENTS**

The following section outlines the specific requirements that should be met by all CHIPP funded programs:

a) **Community Support Plan:** All persons hospitalized over two years will have a CSP and an individualized crisis plan prepared as their plan for discharge. The CSP development begins with the individual, family and a clinical assessment. An external advocate and peer mentor or peer specialist actively engage with individuals in the hospital to inform them about the CSP process and the importance of communicating what the individual believes is most important for them to be able to live successfully in the community. The advocate and peer act as a support to the individual to ensure their voice is heard during the CSP meetings. A facilitator convenes the CSP meeting to prepare a discharge plan that considers the input from the three assessments. The final CSP is the discharge plan that details the services (behavioral and physical) and supports that will be provided, frequency, and the responsible person for each area. An individualized crisis plan is developed and appended to the CSP. Follow-up is conducted to ensure the person receives the services and supports outlined in the CSP. CSPs are to be conducted for all people residing in the hospital over two years. OMHSAS’ goal is to have all hospital discharges guided by a CSP.

b) **Intensive Case Manager (ICM) or Assertive Community Treatment Team (ACT):** All hospitalized individuals discharged as part of CHIPP should be assigned an Intensive Case Manager (ICM), Blended Case Manager, ACT or Community Treatment Team (CTT). OMHSAS Regional Field Offices may approve the assignment of a Resource Coordination where a lesser level of support is needed. The ICM or ACT/CTT member is expected to participate in the CSP planning meetings.

c) **Consumer/Family Satisfaction Teams (C/FST):** All counties receiving CHIPP funding will establish and maintain a C/FST to monitor and evaluate the satisfaction of people receiving CHIPP funded services. C/FSTs shall meet the requirements of the OMHSAS Guidelines for Consumer and Family Satisfaction Teams consistent with the most recent C/FST guidelines in the HealthChoices Behavioral Health (HC-BH) program. It is considered best practice for the CHIPP satisfaction surveys to be conducted by the same teams that assess the HC-BH program. See the attached Appendix L, HealthChoices Behavioral Health - Program Standards and Requirements document.

d) **Consumer Directed Services:** Drop-In Centers, peer mentors or peer specialists, warm lines, and/or other consumer-run services, supports and businesses have proven to be effective in successful community tenure for CHIPP funded individuals, as well as other persons with serious mental illness. It
is recommended that counties utilize CHIPP funding to build on existing consumer-run programs to promote these initiatives.

e) **Integrated Supportive Housing**: Counties should align their plans for promoting and developing integrated supportive housing. CHIPP funding can be used as part of the housing development financing plan.

f) **Use of and Development of Personal Care Homes**: In August 2009, OMHSAS issued a Personal Care Home Policy (Attachment 1), that provides guidance on meeting the housing, treatment and service needs of persons with a mental illness in Personal Care Homes (PCH). It is a goal of OMHSAS that individuals be engaged and supported in identifying and moving into the most integrated housing of choice in their community.

Effective August 18, 2009, no individual discharged from a state hospital can be referred to a PCH with more than 16 beds except as allowed under the exception process in PCH Policy. The development of a Community Support Plan (CSP) shall be required for any individual where such an exception may be considered. The CSP shall identify the rationale for any exception requested to this policy and shall be reported to the OMHSAS Regional Field Office before the CSP becomes final. Please refer to Attachment 1, OMHSAS Personal Care Home Policy for additional information.

Please see Section III, “Identification of an Alternate (Non-original) CHIPP Funded individual”, regarding requirements related to longer term incarceration.

h) **Financial Plan and Funding Requirements**: The cost for a CHIPP proposal is established based on the estimates derived from the cost for services for persons identified for discharge as documented in the CSP, diversionary services and supports, and administrative costs. The CHIPP financing strategy should reflect a unified systems approach to identify all funding sources available for the initiative including county, state and federal funds. As part of the HC-BH Program Medicaid waiver, OMHSAS has developed a rate setting methodology for state hospital bed closures as part of the HC-BH program. The HC rate methodology includes community service costs for MA eligible people discharged from the state hospital and costs for projected diversionary services. HC reinvestment funds, when available, have been effectively used for start-up costs, supportive housing and other services and supports. Individuals to be discharged will also be assessed through the CSP process to determine eligibility for DPW Home and Community Based waivers for individuals with intellectual
challenges, autism, traumatic brain injury, etc., as well as for physical health care needs and benefits.

The budget for a CHIPP proposal includes three budget forms: 1) Start-Up Costs; 2) Program Operation; and 3) Total Start-up and Operations. The projected budget contains personnel costs, operating expenses, equipment, fixed assets, county indirect costs (major object of expenses), and all other revenue sources. The budget will also identify the number of people to be discharged from the state hospital and number projected for diversion. A narrative description that explains and supports the budget request: e.g., providers to be contracted with services included in each major cost center, fixed assets such as the number and type of vehicles to be purchased, etc. should also be submitted.

Funding is to be used to reduce state hospital beds, fund the CSP discharge plans, build community service system infrastructure, and establish oversight functions to manage the program. The Budget Form and Expenditure Reporting Instructions and budget forms for start-up costs and ongoing annualized funding are provided in Attachment 2a and 2b. The budget will be reviewed and approved by appropriate OMHSAS staff. The OMHSAS Deputy Secretary will issue final written approval of the budget.

If the county is unable to accomplish the number of placements specified in the OMHSAS Letter of Agreement, the annualized cost for the program may be reconciled in year two. Flexibility on discharge timeframes may be approved by OMHSAS based on the discharge readiness of an individual or due to unexpected circumstances around the start-up of a program. All CHIPP expenditures must conform to County Code and relevant fiscal regulations. All CHIPP expenditures are subject to an audit conducted by the DPW, Bureau of Financial Operations.

i) **Waiver Request:** If start-up allocations are not able to be spent by June 30th of the fiscal year in which the funds were allocated, a waiver to extend the spending timeframe can be requested prior to the end of the fiscal year. The waiver request should include the rationale for the spending delay, the intended use of the funds and confirmation that the funds can be spent by the end of the first quarter. The County and OMHSAS Regional Field Office will have regular meetings to monitor spending and to anticipate whether a request for a waiver will be needed. Prior to submitting a waiver request, the County should consult with the OMHSAS Regional Field Office to discuss the waiver request and to ensure that OMHSAS will recommend approval to the DPW Office of Administrative Services. Waiver requests are addressed to the DPW Deputy Secretary for the Office of Administrative Services.

j) **Funding Restrictions:** CHIPP funds may not be used to develop or provide services to children and adolescents, or to fund placement in a nursing facility or community private inpatient psychiatric hospital. Effective August 18, 2009, no state funds, including CHIPP, can be used to develop a licensed personal care home with greater than 16 beds.
k) **Nursing Home Placements:** The Federal Omnibus Budget Reconciliation Act of 1987 (OBRA) and subsequent revisions require preadmission screening for all individuals seeking admission to Medicaid (MA)-certified nursing homes. The purpose of the screening is to determine if individuals with mental illness, intellectual disabilities or other related conditions require nursing facility services. Persons in state hospitals, who have had an OBRA screening and have been determined appropriate for a nursing home placement, cannot be considered by the County as CHIPP participants. The CHIPP program budget may, however, include additional behavioral health supports, which, if not provided, could result in continued hospitalization for individuals placed in a nursing facility. Nursing home placements are considered to be funded in full by MA for eligible individuals.

The CSP process should consider all options for community supports that would allow a person to reside in the community rather than a nursing facility.

l) **Discharge to Other Counties:** When an individual served by CHIPP has agreed to and is discharged to another county, the county of origin must have an agreement with the receiving county that spells out the financial and programmatic responsibility of each party. If the discharge will result in a permanent change in residence, adequate funding may need to be permanently transferred to the receiving county in the case of a person with high cost service needs. County requests to change the county code of a currently hospitalized individual must be approved by both the state hospital and the OMHSAS Regional Field Office. If the CHIPP funded individual has a CSP, a CSP meeting will be held to update the plan and ensure that the services and supports based on the individual’s input are in place before the transition is made. The receiving county will then be responsible for ensuring the implementation and monitoring of the CSP.

m) **Implementation Plan and Timeframes:** The final proposal submitted to OMHSAS for CHIPP funding should include an implementation plan and timeframes for the major milestones to be accomplished by June 30th of each year. The implementation plan should include a schedule for the CSP meetings, projected number of people to be discharged each month, development of supported housing and residential services, and hiring and training of staff such as ACT teams, etc.

The county, hospital, OMHSAS Regional Field Office, involved families and individuals will establish a regular meeting schedule to coordinate and provide feedback on implementation of the plan. It is suggested that these meetings be incorporated into the state hospital COC and/or other forums.

**SECTION VI: REPORTING REQUIREMENTS**

a) **CHIPPS Discharge Summary Worksheet:** During the start-up phase of a newly funded CHIPP program the County is required to report to the OMHSAS Regional Field Office monthly on the number of individuals discharged until the
number of state hospital beds targeted for closure has been achieved. The target date to achieve all discharges is June 30th.

b) **CHIPP Statewide Data Base:** In 2005, OMHSAS began the development of a statewide data base to streamline the annual reporting process and to organize enhanced demographic information on people served with CHIPP funds. Effective June 30, 2008, demographic and incident information for all active CHIPP participants is reported within the Home and Community Services Information System (HCSIS). Updates to the CHIPP participant’s CHIPP information, insurance, demographic and other required HCSIS information are made by the county as changes occur. The CHIPP Indicator category of each identified CHIPP individual is verified annually as “Original” or “Alternate”. Additionally, the status is verified as being either “Active” or “Inactive”. If the person’s status as a CHIPP participant is Inactive, the County identifies one option from a drop-down menu to further specify the reason (e.g., Inactive due to long-term nursing facility placement). The annual review affords the County the opportunity to verify other HCSIS-required information as well (e.g., current living situation). See Attachment 3 – Required Data for Inclusion of CHIPP Participants.

A CHIPP individual is defined as a person discharged directly to a CHIPP funded community treatment and support service who has:

- serious mental illness (SMI) and has been in a state hospital for two (2) years or more; or
- complex needs with multiple state hospitalizations and has not been able to be successfully maintained in a community placement; or
- a serious mental illness and needs an enhanced level of treatment and support services to leave a state hospital or to remain in the community and not enter a state hospital; or
- otherwise been approved for CHIPP funding as an “Original” or “Alternate” CHIPP participant.

c) **Reporting Major Incidents:** Effective July 1, 2008, all OMHSAS-reportable incidents for CHIPP participants are recorded within HCSIS, regardless of the type of residence of the CHIPP participant. If the active CHIPP participant is in a Long-Term Structured Residence (LTSR) or Community Residential Rehabilitation Services (CRRS) that provider will continue to create the incident report within HCSIS.

For those OMHSAS-reportable incidents identified by agencies or individuals other than noted above, the County MH program will maintain responsibility for reporting the incident with HCSIS. The CHIPP Participant Reportable Incident Form (Attachment 4) is used to facilitate reporting. The types of incidents to be reported follow the guidelines in the OMHSAS HCSIS Incident Management Bulletin, OMHSAS-06-04, (Attachment 5). Questions about HCSIS reporting of CHIPP participants can be sent via e-mail to CHIPP-HCSIS@state.pa.us.
d) **Letter of Agreement**: The County and OMHSAS will document the final CHIPP agreement through a Letter of Agreement (LOA) after the County CHIPP proposal and the budget have been approved. The LOA will broadly identify the services and supports that will be funded based on the results of the CSPs conducted. Services can change from year to year based on each individual’s needs. The Regional Field Office and the Bureau of Financial Management and Administration each maintain copies of the LOA. The LOA should be developed and signed prior to CHIPP funds being allocated.

**ATTACHMENTS**

- **Attachment 1**: Office of Mental Health and Substance Abuse Services Personal Care Home Policy
- **Attachment 2a**: Budget form and Expenditure Report Instructions
- **Attachment 2b**: Budget forms for start-up costs
- **Attachment 3**: Required Data for inclusion of CHIPP Participants
- **Attachment 4**: CHIPP Participant Reportable Incident Form
- **Attachment 5**: Bulletin OMHSAS-06-04 Community Incident Management & Report System effective date September 1, 2006
- **Appendix L of the Health Choices Behavioral Health Program Standards and Requirements** – “Guidelines for Consumer/Family Satisfaction Teams and Member Satisfaction Surveys”
Office of Mental Health and Substance Abuse Services
Final August 18, 2009

Office of Mental Health and Substance Abuse Services
Personal Care Home Policy

This policy reflects the position of the Office of Mental Health and Substance Abuse Services (OMHSAS) on meeting the housing, treatment and service needs of persons with a mental illness in or referred to Personal Care Homes (PCH). It is a goal of OMHSAS that individuals be engaged and supported in identifying and moving into the most integrated housing* of their choice in the community.

Discussion
The behavioral health system has had a long history of reliance on referral to PCHs to meet the housing and support needs of persons with mental illness. The OMHSAS policy direction seeks to move the mental health system away from reliance on large congregate care settings in communities, such as large PCHs, by making sure that individuals have the choice to live in small, home-like options. Some PCHs are very large, others are smaller and more home like, some embrace recovery principles and others can be isolating or more institutional. Some PCHs are operated by community mental health providers as “enhanced” PCHs that include additional mental health supports for people who need a higher level of support. Living with a group of people is not the way most people want to live given a choice. However, for some people a congregate setting may meet their individual needs. In support of the OMHSAS goal to develop integrated housing options, County MH/MR administrators, as part of the County Mental Health Plan, have developed housing plans to expand the range of housing and supportive services available in their county. Making progress in moving toward integrated housing options requires a cultural shift. Therefore, it is important to establish policy parameters about the development of and referral to PCHs that reduces reliance on large congregate living settings in favor of helping people live in a place they can call home.

Policy

Referral to and Development of a PCH More Than 16 Beds
1. OMHSAS strongly discourages individuals being referred by counties or county contractors to live in any PCH with more than 16 beds. The county shall develop a policy and process, in consultation with consumers and families, to consider any exceptions to this policy. Exceptions should consider the quality of the services and supports provided by a large PCH and other community supports that are available such as Assertive Community Treatment Teams, Peer Support services, etc. The Policy shall:

- Affirm support for and commitment to development of integrated housing options;

* Integrated housing is permanent safe, secure, and affordable housing where an individual holds a lease or other occupancy agreement and where receiving services is not a condition of residence.
Office of Mental Health and Substance Abuse Services
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- Establish the parameters that would need to be met to consider an exception of a referral to a PCH larger than 16 beds;
- Ensure the opportunity for an individual to visit at least two (2) alternative housing options (may include a smaller PCH) that offer greater community integration than a PCH over 16 beds;
- Be reviewed and approved (the county policy) by the OMHSAS Regional Field Office prior to implementation;

2. No individual discharged from a state hospital may be referred to a PCH with more than 16 beds without using the process outlined for granting an exception. Development of a Community Support Plan (CSP) shall be required for any individual where such an exception may be considered. The CSP shall identify the rationale for any exception requested to this policy and shall be reported to the OMHSAS Regional Field Office before the CSP becomes final. See section on state hospital discharge below.

3. OMHSAS will not approve the use of any mental health funds to develop new mental health community based programs such as a Partial Hospitalization Program, Drop-in Centers, Clubhouses, etc., in PCHs (excluding mental health programs in an enhanced PCH) effective August 18, 2009. This does not include direct service provision to individuals living in PCHs by a mental health service provider, such as a Case Manager, Peer Specialist or other mobile service provided specifically to an individual.

4. OMHSAS will not fund the development of any new Enhanced PCH with more than 16 beds. For this purpose, all funds allocated to the county, HealthChoices capitation, and reinvestment dollars are considered OMHSAS funds.

Referral to and Use of Existing PCHs

1. If an individual served by the County MH/IMR Program is being considered for referral to a PCH, the county shall review the licensure status of the home prior to referral to determine if the home has a provisional license. The OMHSAS Regional Field Office and the Regional PCH Field Office shall be consulted prior to considering placement in a home with a provisional license. A county that has an established PCH Risk Management Committee should use this forum to consult on referrals to homes operating on a provisional license. The Committee is comprised of representatives from the County MH/IMR Program, County Area Office on Aging, OMHSAS, Department of Public Welfare’s Adult Residential Licensure, and other key stakeholders.

2. Persons who reside in a PCH that currently also offers on-site behavioral health programs funded by the county shall be given the option to participate in programs offered at an alternative site.
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3. County MH/MR Programs should provide information about integrated housing options and supports to individuals with a serious mental illness living in PCHs operating within their jurisdiction. The information is intended to increase the awareness of individual PCH residents of the opportunities to access and benefit from the community based, recovery oriented treatment and supportive services available to and utilized by individuals with mental illness living in other kinds of housing in the community. The County MH/MR program shall establish mechanisms to provide such information at least twice annually.

Policy for State Hospital Discharge to PCHs Over 16 Beds  
It is the OMHSAS policy that its state hospitals not refer people ready for discharge to a PCH that is larger than 16 beds unless the process outlined below for granting exceptions has been followed. A CSP must be developed for an individual when an exception may be considered to ensure the person has exercised an informed choice and has been offered other housing and support options.

1. The CSP must be conducted to fully understand the housing and support needs of the individual from their perspective. Understanding what is important to the individual is foundational to the CSP process. If a person wants to live in a PCH (or a large PCH), why? Is their choice an informed choice? Is their choice because they believe it is the only option for discharge? Did they live in this PCH successfully in the past? Have they had an opportunity to visit other housing options and learn about supports that may be available?

- What are the services and supports the person wants and believes they need to live successfully in the community?
- What housing and residential options are available in the county or service area? Can new options be developed? Is the person interested in moving?
- Does the person want a private bedroom?
- Will the person be living close to family, friends, and activities that are important in their life?
- Is the home close to options for potential or desired employment and occupational choices?
- Does the person need PCH level of support (assistance with activities of daily living)? Can intensive case management or assertive community treatment teams/community treatment teams provide such supports in a more independent housing option?

2. The CSP shall document that the individual (and family member if involved) was provided a choice of housing or residential options and given the opportunity to visit these options prior to any consideration for a PCH over 16 beds. Documentation shall include the rationale for the individual’s choice.

3. Any discharge in which a person may be considered for an exception shall be reported to the OMHSAS Regional Office before the CSP becomes final.
Office of Mental Health and Substance Abuse Services
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4. If a state hospital is considering a referral to a PCH, the hospital in coordination with the county, shall review the licensure status of the home prior to referral to determine if the home has a provisional license. The OMHSAS Regional Field Office and the Regional PCH Field Office shall be consulted prior to considering placement in a home with a provisional license.

5. An exception to the policy can be made when all of the following exist:
   - This is where the person wants to live;
   - No other housing options are available or viable for the individual;
   - The individual does not want to move to another county;
   - The PCH and community supports meet the person's needs as documented in the CSP; and
   - Without making an exception the person would not be able to be discharged from the state hospital.

When an exception is made, the CSP shall also include a timeline and plan for moving to the most integrated community housing appropriate that reflects the individual’s choice and that is less than 16 beds.

6. If a county has no placement options other than large PCHs, the Service Area Planning group should identify and prioritize housing development plans for the county and consider regional housing development plans for the service area.

7. All CSP team members shall be trained in the requirements of this guidance document. Consumers and families participating in the CSP process shall be informed of this policy and process to consider exceptions.
Office of Mental Health and Substance Abuse Services

Budget Form and Expenditure Report Instructions
Community Hospital Integration Projects Program (CHIPP)

The three CHIPP Budget Forms, 1.) Startup Costs, 2.) Program Operation, and 3.) Total Startup and Operation, must be completed by counties receiving CHIPP funding. First, the forms must be used to present the county’s proposed CHIPP budget. Secondly, upon approval of the proposed budget by OMHSAS, the same forms must also be used to report expenditures, as described below.

County Program Information

In the heading of each form:
- Enter the name of the county MH/MR program in the upper left corner.
- Enter the page number in the upper right corner.
- Check either “Budget”, “Six Month Report”, or “Annual Report” box in the upper right corner, as appropriate.
- Enter the fiscal year.

Each form must be signed by the County Administrator and dated in the spaces provided at the bottom of the page.

General Instructions

The CHIPP Budget and Report forms use a format similar to the DPW MH/MR Income and Expenditure (I&E MH/MR 17 form) Report.
- Each page of the form contains columns for up to seven cost centers (e.g. Administrator’s Office, Community Services, Case Management, Vocational Rehabilitation, etc.). Additional pages should be used for additional cost centers as needed.
- In the space provided at the top of each column, enter the name of the cost centers used for CHIPP funds.
- Use only the officially designated mental health cost centers utilized in the annual DPW MH/MR I&E Report.
- Include county administrative costs in the Administrator’s Office cost center.
- Finally, use the “Total” column to show the sum of the amounts appearing in each expenditure line and cost center.

Expenditure Information

All CHIPP expenditures funded by the OMHSAS allocation are to be shown by the object of expense (line) and cost center (column). Costs should be cumulative from the beginning of the fiscal year in the six-month reports. For example, the first six-month report will reflect expenditures from January 1st through June 30th. The annual report will include expenditures for the entire fiscal year.
- Line “E. Total for Cost Center” reflects the total expenditures for each cost center.
• In Line “F. OMHSAS Reimbursement” enter the portion of Line E, funded with the CHIPP allocation.
• Line “G. Projected MA & Other Revenue” is used to project or report Medicaid and other revenue sources (program service fees, private insurance, room and board, interest, and other).

Client Information

Two lines are provided at the bottom of the form for projected (Budget) or actual (Report) clients served. Separate lines are provided and separate entries should be made for clients discharged and clients diverted from admission, for each cost center. Within each cost center, client counts should be unduplicated.

Rebudget Approval

Budget revisions may be submitted to OMHSAS for approval at any time. Proposed changes in cost centers that exceed the following criteria must be approved by the OMHSAS Field Office:

• In cost centers of $500,000 or more, any change of 5% or greater must be approved.
• In cost centers less that $500,000, any change of 20% or $25,000, whichever is smaller, must be approved.
• Any change less than $1,000 does not require approval.

Questions

Questions regarding the CHIPP budget and expenditure reporting requirements should be directed to the OMHSAS Bureau of Financial Management and Administration or the Field Office Manager.

June 2006
<table>
<thead>
<tr>
<th>Cost Center</th>
<th>Cost Center</th>
<th>Cost Center</th>
<th>Cost Center</th>
<th>Cost Center</th>
<th>Cost Center</th>
<th>Cost Center</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Personnel Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>$0.00</td>
</tr>
<tr>
<td>B. Operating Expenses</td>
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<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>1. Occupancy</td>
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<td></td>
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<td></td>
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<td>$0.00</td>
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<tr>
<td>a. Real Estate Purchases</td>
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<td>b. Renovations/Construction</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>c. Mortgage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>d. Rent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>e. Other</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2. Communication</td>
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<td>3. Administrative Supplies</td>
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<td>4. Treat. &amp; Support Supplies</td>
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<td></td>
<td></td>
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<tr>
<td>5. Transportation</td>
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<td>$0.00</td>
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<tr>
<td>6. Purchased Treat. Services</td>
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<td>$0.00</td>
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<td>7. Misc. Operating Expenses</td>
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<td>$0.00</td>
</tr>
<tr>
<td>8. Operating Subtotal</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>C. Equipment and Fixed Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>D. County Indirect Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>E. TOTAL EXPENDITURES</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>F. OMHSAS Reimbursement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>G. Projected MA &amp; Other Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>TOTAL FUNDING</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Discharge Clients  $0.00  Diversion Clients  $0.00  TOTAL CLIENTS  0 0 0 0 0 0 0 0
**OMHSAS Home and Community Services Information System (HCSIS):**
**Required Data for Inclusion of CHIPP Participants**

**HCSIS Individual Clearance Screen**

<table>
<thead>
<tr>
<th>HCSIS Field Name</th>
<th>Description of Required Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>Enter the last name of the CHIPP participant.</td>
</tr>
<tr>
<td>Middle Initial</td>
<td>Enter the middle initial of the CHIPP participant’s name. Leave the field blank if unknown.</td>
</tr>
<tr>
<td>First Name</td>
<td>Enter the first name of the CHIPP participant. Use the person’s proper name (not a nickname or initials).</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Enter the CHIPP participant’s date of birth, in a format of MM/DD/YYYY (for example, 01/21/1962).</td>
</tr>
<tr>
<td>Gender</td>
<td>Select from the drop-down menu the CHIPP participant’s gender as either:</td>
</tr>
<tr>
<td></td>
<td>- Male</td>
</tr>
<tr>
<td></td>
<td>- Female</td>
</tr>
<tr>
<td>Citizenship</td>
<td>Select from the drop-down menu the CHIPP participant’s citizenship as one of the following only:</td>
</tr>
<tr>
<td></td>
<td>- US Citizen</td>
</tr>
<tr>
<td></td>
<td>- Permanent Alien</td>
</tr>
<tr>
<td></td>
<td>- Temporary Alien</td>
</tr>
<tr>
<td></td>
<td>- Refugee</td>
</tr>
<tr>
<td></td>
<td>- Illegal Alien</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Select from the drop-down menu the CHIPP participant’s ethnicity as either:</td>
</tr>
<tr>
<td></td>
<td>- Hispanic</td>
</tr>
<tr>
<td></td>
<td>- Non-Hispanic</td>
</tr>
<tr>
<td>Race</td>
<td>Select from the drop-down menu the CHIPP participant’s race (may select no more than 5):</td>
</tr>
<tr>
<td></td>
<td>- Black or African American</td>
</tr>
<tr>
<td></td>
<td>- American Indian or Alaskan Native</td>
</tr>
<tr>
<td></td>
<td>- Asian</td>
</tr>
<tr>
<td></td>
<td>- White</td>
</tr>
<tr>
<td></td>
<td>- Other</td>
</tr>
<tr>
<td></td>
<td>- Native Hawaiian or Pacific Islander</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>Enter the Social Security Number of the CHIPP participant. This is a 9-digit numeric field. Do not enter hyphens or spaces.</td>
</tr>
</tbody>
</table>
**HCSIS Alternate Identifier Screen**

<table>
<thead>
<tr>
<th>HCSIS Field Name</th>
<th>Description of Required Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifier Type</td>
<td>Select the Alternate Identifier Type of identification number from the drop down.</td>
</tr>
<tr>
<td>Identifier #</td>
<td>Enter the CHIPP participant’s identifier number. Do not enter spaces or hyphens.</td>
</tr>
<tr>
<td>Is Effective Begin Date Known?</td>
<td>Drop-down yes or no. For Social Security number always use no.</td>
</tr>
<tr>
<td>Effective Begin Date</td>
<td>Enter the effective begin date as MM/DD/YYYY. When entering “no” to “effective begin date known” 01/01/1900 will automatically appear.</td>
</tr>
<tr>
<td>Effective End Date</td>
<td>Enter the effective end date as MM/DD/YYYY.</td>
</tr>
</tbody>
</table>
OMHSAS Home and Community Services Information System (HCSIS):
Required Data for Inclusion of CHIPP Participants

HCSIS Primary Demographics Screen

<table>
<thead>
<tr>
<th>HCSIS Field Name</th>
<th>Description of Required Data</th>
</tr>
</thead>
</table>
| Living Situation   | Select from the drop-down menu the one value that best describes the CHIPP participant’s current living situation:  
- Assisted Living Residence (ALR) – A significant long-term care alternative to allow individuals to age in place, where residents will receive the assistance they need to age in place and develop and maintain maximum independence, exercise decision-making and personal choice. Issued a Certificate of Compliance from DPW (aka, “licensed” by DPW) under 55 Pa. Code Chapter 2800.  
- Community Residential Rehabilitation Services (CRRS) - A transitional residential program in a community setting for adults with a psychiatric disability that provides housing, personal assistance and psychosocial rehabilitation. A CRRS is issued a Certificate of Compliance from DPW (aka, “licensed” by DPW) under 55 Pa. Code Chapter 5310.  
- Correction/Detention Facility - A corrections facility where an individual is incarcerated for criminal charges or conviction.  
- D & A Residential Facility - A facility licensed by the Department of Health as a residential drug & alcohol treatment program.  
- Domiciliary Care - Private residences that provide services for no more than 3 persons; individuals and/or couples age 19 years or older. Domiciliary Care Homes are certified by the Department of Aging.  
- Friend’s Home (Defined as a home, apartment, condominium, townhouse, house, trailer, etc. which is not subject to licensing that is owned, leased or rented by an individual who is known to the CHIPP participant).  
- Group Home - Other congregate living situation not licensed by the Department, where unrelated adults reside in a residence not owned/leased by a resident.  
- Homeless (Defined as currently without a permanent living address).  
- LTSR – A highly structured therapeutic residential mental health treatment facility for adults |

HCSIS-CHIPP Data Definitions 3 of 9 03/05/2010
### OMHSAS Home and Community Services Information System (HCSIS):
**Required Data for Inclusion of CHIPP Participants**

<table>
<thead>
<tr>
<th>Living Situation (continued)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Nursing Home/Nursing Facility – A long term nursing facility that provides skilled and/or intermediate care and is licensed by the Department of Health.</td>
<td></td>
</tr>
<tr>
<td>Other – A residence not otherwise identified in this list of residential settings.</td>
<td></td>
</tr>
<tr>
<td>Other Independent Living (Defined as living independently other than in one's own residence or the residence of a family member or friend)</td>
<td></td>
</tr>
<tr>
<td>Own Residence (Defined as a home, apartment, condominium, townhouse, house, trailer, etc. that is owned, leased or rented by the individual receiving services - is not subject to licensing).</td>
<td></td>
</tr>
<tr>
<td>Personal Care Home (PCH) - Any premises where four or more unrelated adults who do not require nursing care reside and receive food, shelter and personal care, financial management or supervision for periods exceeding 24 continuous hours. Issued a Certificate of Compliance from DPW (aka, “licensed” by DPW) under 55 Pa. Code Chapter 2600.</td>
<td></td>
</tr>
<tr>
<td>Personal Care Home Specialized/Enhanced - A PCH “licensed” by DPW under 55 Pa. Code Chapter 2600 and having additional specialized mental health services provided on site.</td>
<td></td>
</tr>
<tr>
<td>RTFA - A mental health residential treatment facility for adults who do not need hospitalization but require 24 hour supervision.</td>
<td></td>
</tr>
<tr>
<td>Relative's Home (Defined as living in the home of biological or adoptive relative, regardless of the individual's age. Relatives may include grandparents, aunts/uncles, etc.)</td>
<td></td>
</tr>
<tr>
<td>State Mental Health Hospital – A psychiatric inpatient facility operated by DPW OMHSAS.</td>
<td></td>
</tr>
<tr>
<td>Supported Living (MH) - A mental health program which provides affordable housing, direct support services and training on such living skills as: cooking, apartment upkeep, personal hygiene, money and time management, transportation, use of community services and vocational assistance.</td>
<td></td>
</tr>
<tr>
<td>Temporary Shelter (Defined as living in a shelter on temporary basis while seeking more permanent housing).</td>
<td></td>
</tr>
</tbody>
</table>
### OMHSAS Home and Community Services Information System (HCSIS):
#### Required Data for Inclusion of CHIPP Participants

<table>
<thead>
<tr>
<th>County of Residence</th>
<th>Select the name of the county from the drop-down list in which the CHIPP participant physically resides/receives residential services.</th>
</tr>
</thead>
</table>
**OMHSAS Home and Community Services Information System (HCSIS): Required Data for Inclusion of CHIPP Participants**

**HCSIS Individual Address Screen**

<table>
<thead>
<tr>
<th>HCSIS Field Name</th>
<th>Description of Required Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Line 1</td>
<td>Enter the first line of the CHIPP participant’s street address.</td>
</tr>
<tr>
<td>Address Line 2</td>
<td>Enter the second line of the CHIPP participant’s address, if applicable.</td>
</tr>
<tr>
<td>Address Line 3</td>
<td>Enter any additional address information not included in the first two lines of the address, if applicable.</td>
</tr>
<tr>
<td>City</td>
<td>Enter the name of the city/town where the CHIPP participant resides.</td>
</tr>
<tr>
<td>State</td>
<td>Select “Pennsylvania” from the drop down box to indicate the state in which the CHIPP participant’s address/city is located. If it is a state other than Pennsylvania, data enter the name of the state (e.g., Maryland).</td>
</tr>
<tr>
<td>Zip</td>
<td>Enter the zip code for the location of the CHIPP participant’s address.</td>
</tr>
<tr>
<td>Address Type</td>
<td>Select an address type from the drop down box. (Residential, Mailing or Residential/Mailing) If this address is both the residential and mailing address, select the Residential/Mailing option. If this address is the residential address only, select the Residential option. If the CHIPP participant’s mail is sent to a place other than their residential address, enter the mailing address using the Mailing option.</td>
</tr>
<tr>
<td>Address Effective Begin Date</td>
<td>Enter the effective begin date that the current address became valid. Use the format MM/DD/YYYY (e.g., 04/24/2007). If the address effective date is unknown, enter 01/01/1900 as the default date, and correct the Address Effective Begin Date at the earliest convenience.</td>
</tr>
</tbody>
</table>
### HCSIS CHIPP Consumer Information Screen

<table>
<thead>
<tr>
<th>HCSIS Field Name</th>
<th>Description of Required Data</th>
</tr>
</thead>
</table>
| CHIPP Indicator  | Select from the drop-down menu the one status that best identifies the CHIPP participant:  
  - Original – A person with Serious Mental Illness (SMI) who has been in a state mental hospital for two (2) years or more (or person with complex needs who has had multiple state hospitalizations and who has not been able to be successfully maintained in a community placement) who is discharged directly to CHIPP-funded, community treatment and support services during Year One of a CHIPP funded initiative. An Original CHIPP participant is entered into HCSIS upon discharge from the state hospital and will be tracked indefinitely. Counties will be required to report changes within HCSIS. Should an original CHIPP participant become inactive during the 2 years following discharge from the state hospital, an “Alternate” CHIPP must be named.  
  - Alternate - A person who enters the program when a vacancy occurs as the result of a change in status for an “Original” CHIPP participant (i.e., CHIPP participant becomes “Inactive” within 2 years following his/her discharge from the state hospital). The new CHIPP individual is identified by the County.  
  - Not CHIPP  
  NOTE: If the selected CHIPP Indicator is “Original” or “Alternate”, the following fields become mandatory:  
  * CHIPP Funded County; CHIPP Original County; Original Fiscal Year |
| Hospital Name    | Select from the drop-down menu the hospital that the CHIPP participant was originally discharged as a CHIPP or was discharged as a closure. If CHIPP not directly discharged from SMH select “No Hospital.” |
| Special Group    | The drop-down menu with closure or non-closure will only appear if a closed hospital is selected. |
| Status           | Select active or inactive from the drop-down menu.  
  NOTE: If the selected CHIPP Indicator is “Inactive”, the following fields become mandatory:  
  * Reason for Inactive  
  * CHIPP Funded County  
  * CHIPP Original County  
  * Original Fiscal Year |
OMHSAS Home and Community Services Information System (HCSIS): Required Data for Inclusion of CHIPP Participants

HCSIS CHIPP Consumer Information Screen (continued)

<table>
<thead>
<tr>
<th>HCSIS Field Name</th>
<th>Description of Required Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Inactive</td>
<td>Select from the drop-down menu the one reason to indicate why the CHIPP participant’s status is “Inactive”. This field is required if the CHIPP indicator is “Inactive”:</td>
</tr>
<tr>
<td></td>
<td>- Deceased - An Original or Alternate CHIPP participant who is deceased.</td>
</tr>
<tr>
<td></td>
<td>- State Hospital - An Original or Alternate CHIPP participant, who is admitted or readmitted to a state mental hospital, and has remain hospitalized or is expected to remain hospitalized for 6 months or more, and is no longer receiving county-funded mental health services.</td>
</tr>
<tr>
<td></td>
<td>- LT Nursing Home - An Original or Alternate CHIPP participant who is admitted to a skilled nursing facility/nursing home and is not expected to return to his/her previous CHIPP funded services and is no longer receiving county-funded mental health services.</td>
</tr>
<tr>
<td></td>
<td>- Incarceration - An Original or Alternate CHIPP participant who enters jail or prison and is expected to remain incarcerated for 6 months or more and is no longer receiving county-funded mental health services.</td>
</tr>
<tr>
<td></td>
<td>- Out of Area - An Original or Alternate CHIPP participant who chooses to move to another state and is referred to services there.</td>
</tr>
<tr>
<td></td>
<td>- Refused Services - An Original or Alternate CHIPP participant who actively refuses to accept CHIPP funded services and chooses to terminate contact for at least 6 months, or a person who abruptly chooses to terminate contact and his/her whereabouts is unknown.</td>
</tr>
<tr>
<td></td>
<td>- Other - An Original or Alternate CHIPP participant who is no longer receiving CHIPP funded services and is not known to be in any of the above categories.</td>
</tr>
<tr>
<td>Effective Inactive Date</td>
<td>If the CHIPP participant’s status within the CHIPP Indicator field is “Inactive”, enter the date the individual effectively became inactive as a CHIPP participant. Use the format of MM/DD/YYYY (for example, 06/04/2007).</td>
</tr>
<tr>
<td>Cause of Death</td>
<td>If the CHIPP participant’s status within the CHIPP indicator field is “Inactive”, and the reason for inactive is “Deceased”, select from the drop-down menu the one option that best describes the cause of death:</td>
</tr>
<tr>
<td></td>
<td>- Accident</td>
</tr>
<tr>
<td></td>
<td>- Natural Causes</td>
</tr>
<tr>
<td></td>
<td>- Other</td>
</tr>
<tr>
<td></td>
<td>- Suicide</td>
</tr>
<tr>
<td>Date of Death</td>
<td>If the CHIPP participant’s status within the CHIPP indicator field is “Inactive” and the reason for inactive is “Deceased”, enter the date of death of the individual. Use the format of MM/DD/YYYY (for example, 06/04/2007). For CHIPP participants who became inactive due to death, the Effective Inactive Date and</td>
</tr>
</tbody>
</table>
the Date of Death will be identical.

### HCSIS CHIPP Consumer Information Screen (continued)

<table>
<thead>
<tr>
<th>HCSIS Field Name</th>
<th>Description of Required Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the person an MFP Consumer</td>
<td>Select from the drop-down menu yes or no.</td>
</tr>
<tr>
<td>Comments</td>
<td>Enter any comments relative to the CHIPP participant’s status (e.g., use the comments section to provide a brief explanation of circumstances to explain the selection of “Other” as the reason why the CHIPP participant is on inactive status).</td>
</tr>
<tr>
<td>CHIPP Funded County</td>
<td>Select from the drop-down menu the name of the County currently responsible for the CHIPP services. In most cases this field will be identical to the CHIPP Funded County.</td>
</tr>
<tr>
<td>CHIPP Original County</td>
<td>Select from the drop-down menu the name of the County originally responsible for the CHIPP services.</td>
</tr>
<tr>
<td>Original FY</td>
<td>Select from the drop-down menu the original state Fiscal Year (FY) of the recipient’s initial CHIPP-funded discharge. If the person had been discharged as a CHIPP in a previous year, then readmitted to a state mental hospital and discharged again, enter only the earliest FY the participant was CHIPP-funded.</td>
</tr>
<tr>
<td>Admission Date</td>
<td>Enter the date that the CHIPP participant was admitted to the State Hospital. Use the format MM/DD/YYYY (e.g., 08/30/2003). If the CHIPP participant was not directly discharged from a state mental hospital (e.g., was a hospital diversion), leave field blank.</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>Enter the date that the CHIPP participant was discharged from the State Hospital. Use the format MM/DD/YYYY (e.g., 09/16/2006). If the CHIPP participant was not directly discharged from a state mental hospital (e.g., was a hospital diversion), leave the field blank.</td>
</tr>
<tr>
<td>Primary Provider</td>
<td>Enter the name of the mental health provider that provides the primary, formal support service for the CHIPP participant. If the person lives in a licensed mental health residential program (e.g., Community Residential Rehabilitation Services) the legal entity name of the provider that operates the residential program should be data entered (e.g., Southwestern Mental Health Services). If the person lives independently or with family, the primary provider would be the name of the local Base Service Unit or Case Management Unit.</td>
</tr>
</tbody>
</table>
# OMHSAS Home and Community Services Information System (HCSIS)

## CHIPP Participant Reportable Incident Form

### REPORTING ENTITY INFORMATION

<table>
<thead>
<tr>
<th>Name of Provider (Legal Entity Name):</th>
<th>Telephone Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
<th>County:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Person Completing the Form (and his/her position):</th>
<th>Telephone Number:</th>
</tr>
</thead>
</table>

### CHIPP PARTICIPANT INFORMATION (Leave Blank if Site-Level Incident)

<table>
<thead>
<tr>
<th>Name of CHIPP Participant:</th>
<th>Date of Birth:</th>
<th>SSN:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Citizenship:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Citizen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Alien</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary Alien</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illegal Alien</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African American</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address of CHIPP Participant:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Living Situation:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted living Residence (ALR)</td>
<td></td>
</tr>
<tr>
<td>Correction/Detention Facility</td>
<td></td>
</tr>
<tr>
<td>D&amp;A Residential Facility</td>
<td></td>
</tr>
<tr>
<td>Domiciliary Care</td>
<td></td>
</tr>
<tr>
<td>Nursing Home/Nursing Facility</td>
<td></td>
</tr>
<tr>
<td>Group Home</td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Other Independent Living</td>
<td></td>
</tr>
<tr>
<td>Personal Care Home</td>
<td></td>
</tr>
<tr>
<td>Personal Care Home Specialized/Enhanced</td>
<td></td>
</tr>
<tr>
<td>RTFA</td>
<td></td>
</tr>
<tr>
<td>Relative’s Home</td>
<td></td>
</tr>
<tr>
<td>Supported Living</td>
<td></td>
</tr>
<tr>
<td>Temporary Shelter</td>
<td></td>
</tr>
</tbody>
</table>

### INCIDENT INFORMATION

| Date of Incident: | Time of Incident: | |
|-------------------|-------------------|
| Name of Person Initially Reporting the Incident (and his/her position): | Telephone Number: |

<table>
<thead>
<tr>
<th>Date and Time the Initial Reporter Became Aware of the Incident:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Incident Point Person:</th>
</tr>
</thead>
</table>

---

Attachment 4

OMHSAS Home and Community Services Information System (HCSIS)

CHIPP Participant Reportable Incident Form
**TYPE OF INCIDENT** (Check only the one category and the one corresponding subcategory that best classifies the incident)

<table>
<thead>
<tr>
<th>Abuse: Individual to Individual</th>
<th>Abuse: Staff to Individual</th>
<th>Death</th>
<th>Fire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploitation</td>
<td>Exploitation</td>
<td>Accident</td>
<td>W/ Property Damage</td>
</tr>
<tr>
<td>Physical</td>
<td>Physical</td>
<td>Homicide</td>
<td>W/O Property Damage</td>
</tr>
<tr>
<td>Psychological</td>
<td>Psychological</td>
<td>Natural Causes</td>
<td>Other</td>
</tr>
<tr>
<td>Sexual</td>
<td>Sexual</td>
<td>Suicide</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

| Exploitation                      | Exploitation              | Accident | W/ Property Damage |
| Physical                          | Physical                  | Homicide | W/O Property Damage |
| Psychological                     | Psychological             | Natural Causes | Other |
| Sexual                            | Sexual                    | Suicide    | Other |
| Other                             | Other                     | Other      | Other |

<table>
<thead>
<tr>
<th>Illness</th>
<th>Injury</th>
<th>Law Enforcement Activity</th>
<th>Missing Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoH Reportable Illness</td>
<td>ER Tx./Medical Office</td>
<td>Crisis Intervention</td>
<td>Immediate Jeopardy</td>
</tr>
<tr>
<td>ER Tx./Medical Office</td>
<td>Hospital</td>
<td>Charged with a crime</td>
<td>Missing over 24 Hours</td>
</tr>
<tr>
<td>Hospital</td>
<td>Other</td>
<td>Victim of a crime</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Site crime</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neglect</th>
<th>Restrictive Procedure</th>
<th>Significant Medication Error</th>
<th>Suicide Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to Provide Care</td>
<td>Restrained / Injury</td>
<td>ER Tx./Medical Office</td>
<td>ER Tx./Medical Office</td>
</tr>
<tr>
<td>Other</td>
<td>Restrained w/o Injury</td>
<td>Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td>Other</td>
<td>Seclusion</td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

**INCIDENT INFORMATION** (cont’.)

<table>
<thead>
<tr>
<th>Was CPR Administered?</th>
<th>Is Incident Location Known? (If “Yes”, state the relationship of the location to the individual, and the location address.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**BRIEF DESCRIPTION OF INCIDENT**

(Provide at least the following information: Where did the incident happen? What were the circumstances leading up to the incident?)
### WITNESS INFORMATION

Were there witnesses to the incident (other than the Initial Reporter)?

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Name of Witness</th>
<th>Relationship to Individual</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TARGET INFORMATION

(The “Target” is an employee or other person involved in the incident.)

Were there targets identified for the incident (other than the CHIPP Participant)?

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Name of Target</th>
<th>Relationship to Individual</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relocated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suspended</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Terminated</td>
</tr>
</tbody>
</table>

### NOTIFICATION INFORMATION

Has notification to involved parties been made of this incident (other than via this incident report form)?

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Family or Type of Agency Contacted</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>County MH Program</td>
<td>No Change</td>
</tr>
<tr>
<td>County D&amp;A</td>
<td>Relocated</td>
</tr>
<tr>
<td>County Office of Aging</td>
<td>Other</td>
</tr>
<tr>
<td>Family</td>
<td>Suspended</td>
</tr>
<tr>
<td>PA Dept. of Health</td>
<td>Terminated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Person Notified</th>
<th>Date Notified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Making Contact</th>
<th>Additional Information/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
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</tr>
</thead>
<tbody>
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<td>No Change</td>
</tr>
<tr>
<td>County D&amp;A</td>
<td>Relocated</td>
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<tr>
<td>County Office of Aging</td>
<td>Other</td>
</tr>
<tr>
<td>Family</td>
<td>Suspended</td>
</tr>
<tr>
<td>PA Dept. of Health</td>
<td>Terminated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Person Notified</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Person Making Contact</th>
<th>Additional Information/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
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</thead>
<tbody>
<tr>
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<td>No Change</td>
</tr>
<tr>
<td>County D&amp;A</td>
<td>Relocated</td>
</tr>
<tr>
<td>County Office of Aging</td>
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<tr>
<th>Name of Person Notified</th>
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</thead>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>Person Making Contact</th>
<th>Additional Information/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HOSPITALIZATION INFORMATION
(Complete this section only if this incident had a subcategory of “Hospital” on page 2 under Type of Incident).

<table>
<thead>
<tr>
<th>Date of Admission:</th>
<th>Hospital Name:</th>
<th>Admitting Diagnosis:</th>
</tr>
</thead>
</table>

What occurred during the hospitalization?
- [ ] Observation
- [ ] Special Studies
- [ ] Surgical
- [ ] Other (specify):  

<table>
<thead>
<tr>
<th>Date of Discharge:</th>
<th>Discharge Diagnosis:</th>
<th>Have follow-up appointments been scheduled?</th>
</tr>
</thead>
</table>
|                    |                      | [ ] Admitting Physician  
|                    |                      | [ ] Admitting Psychiatrist  
|                    |                      | [ ] Outpatient Psychiatrist  
|                    |                      | [ ] PCP  
|                    |                      | [ ] Specialist  
|                    |                      | [ ] Surgeon  
|                    |                      | [ ] None |

Were there any changes to the individual’s medication or to the treatment plan? (explain):  

### DEATH INFORMATION
(Complete this section only if this incident had a category of “Death” on page 2 under Type of Incident).

<table>
<thead>
<tr>
<th>Date of Death:</th>
<th>Was the coroner contacted?</th>
<th>Was or will an autopsy be performed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Yes  [ ] No  [ ] Unknown</td>
<td>[ ] Yes  [ ] No  [ ] Unknown</td>
</tr>
</tbody>
</table>

Indicate what supplemental information exists for this report (and forward hard copies of available documents to the County MH Program and to the OMHSAS Field Office):

- [ ] Autopsy Report
- [ ] Copy of Death Certificate
- [ ] (Hospital) Discharge Summary
- [ ] (Lifetime) Medical History
- [ ] Results of recent health and medical assessments
- [ ] Results of most recent physical exam
- [ ] Other (specify):  

Was the individual hospitalized just prior to death?
- [ ] Yes  [ ] No  [ ] Unknown |

### CORRECTIVE ACTION INFORMATION

Will there be corrective action in response to this incident?
- [ ] Yes  [ ] No |

Corrective Action (specify):  

<table>
<thead>
<tr>
<th>Name of Responsible Person:</th>
<th>Completion Date/Expected Completion Date:</th>
</tr>
</thead>
</table>

### FOR COUNTY MH/MR PROGRAM USE ONLY:

Date and time the Incident Report Form was received by the County:  

Date the incident was reported by the County in HCSIS:  

Date the County reviewed /updated consumer’s HCSIS Demographic and CHIPP screens:
Mental Health and Substance Abuse Services Bulletin
COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE

NUMBER: OMHSAS-06-04
ISSUE DATE: July 18, 2006
EFFECTIVE DATE: September 1, 2006

SUBJECT: Community Incident Management & Report System

BY: Joan Erney
Deputy Secretary for Office of Mental Health and Substance Abuse Services

SCOPE:
Community Residential Rehabilitation Service Providers
Long Term Structured Residence Providers
County MH/MR Administrators

Definitions:

Community Residential Rehabilitation Services—Transitional residential programs in community settings for persons with chronic psychiatric disability to assist in their recovery.

Department—The Department of Public Welfare of the Commonwealth.

HCSIS—Home and Community Services Information System.

Investigation—For the purposes of this Bulletin, investigation refers to activities conducted by the provider, county or OMHSAS to determine the circumstances surrounding the reported incident which forms the basis of follow-up activities or corrective action. Although it does not specify the use of a certified investigator, it is expected that investigators be adequately trained and certified investigators may be used if they are available. OMHSAS may modify the Bulletin at some point in the future should it be determined that certified investigators are needed to adequately investigate incidents. Further, it does not preclude investigations by law enforcement agencies.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Office of Mental Health and Substance Abuse Services, Division of Quality Management, P.O. Box 2675, Harrisburg, PA 17105. 717-772-6650 (General Office Number).
Long Term Structured Residence—A highly structured therapeutic residential mental health treatment facility for adults.

OMHSAS—Office of Mental Health and Substance Abuse Services

Licensing Applicability:

Following the processes outlined in this policy statement satisfies the incident reporting requirements of 55 Pa. Code (relating to public welfare) for the following regulation chapters:

- Chapter 20 – Licensure or Approval of Facilities and Agencies
- Chapter 5310 – Community Residential Rehabilitation Services for the Mentally Ill
- Chapter 5320 – Long Term Structured Residences

PURPOSE:

The purpose of this Bulletin is to establish guidelines and procedures for a consistent statewide process for reporting, categorizing and investigating incidents involving consumers in the public mental health system. This process also includes the structure for taking immediate corrective actions as well as analyzing incident trends to prevent recurrence. As a result, the Commonwealth’s behavioral health system will be better able to systematically monitor and protect the health, safety, dignity, rights and welfare of consumers receiving services and treatment.

BACKGROUND:

Providers of mental health (MH) services throughout the public mental health system need to ensure that safeguards are in place to protect the health, safety and rights of consumers receiving these services. OMHSAS intends to have a unified incident reporting system for county mental health programs and providers. All providers of mental health services, including the county mental health programs, behavioral health managed care organizations, and OMHSAS are partners in the effort to assure the health, safety, dignity, rights and welfare of persons receiving mental health services.

DISCUSSION:

The primary goal of an incident management system is to assure that the response, review, and analysis of incidents is adequate to protect the health, safety and rights of the consumer. This bulletin communicates and standardizes clear and specific processes at the provider and county levels for reporting and follow-up of incidents. The continuous review and analysis of incidents is aimed at protecting consumers, identifying trends and formulating action to prevent recurrence. It is understood that all reported events do not necessarily represent a treatment failure or a failure on the part of the provider.
In addition to the OMHSAS reporting processes described in this bulletin, reporting requirements of other laws and regulations must be followed. Notwithstanding the guidelines in the statement of policy, facilities remain obligated to follow the requirements of 18 PA CS 2713 (relating to neglect of care-dependent persons), 35 P. S. §§ 10225.101—10225.5102 (notification requirements of the Older Adults Protective Services Act), and 23 Pa.C.S. § 6301—6384 (relating to Child Protective Services Law). Furthermore, these standards do not preclude counties from requiring additional reporting.

Facilities must comply with the requirements of 55 Pa. Code Chapters 20, 5310, and 5320. Because this statement of policy meets or exceeds the regulatory requirements of Chapters 20, 5310, and 5320, compliance with the reporting procedures in this statement of policy will be accepted as meeting the regulatory requirements (relating to reporting of incidents).

**REPORTING RESPONSIBILITIES:**

Responsibility for reporting an incident as outlined in this policy, including the use of the standardized reporting tools, is as follows:

- Residential providers, licensed by OMHSAS, limited to Community Residential Rehabilitation Services (CRRS) and Long Term Structured Residences (LTSR). These entities are responsible for completing incident reports on those in their care, including incidents for any consumer enrolled in the CRR or LTSR that occur while the consumer is in the community. Counties are to request the cooperation of providers not covered by the scope of this bulletin in the reporting and investigation of an incident by the residential provider or county program.

Reports are to be made through the Department of Public Welfare’s Home and Community Services Information System (HCSIS). The initial notification of the occurrence of an incident is due within 24 hours after the incident, or within 24 hours after the provider learns of the incident.

**INCIDENTS TYPES:**

The following lists the different types of incidents to be reported.

**Death** - all deaths regardless of cause.

**Suicide Attempt**: - The intentional and voluntary attempt to take one’s own life. A suicide attempt is limited to the actual occurrence of an attempt which requires medical treatment and/or where the consumer suffers or could have suffered significant injury or death.

Non-reportable events include:

- Threats of suicide which do not result in an actual attempt.
• Gestures which clearly do not place the consumer at risk for serious injury or death.
• Actions which may place the consumer at risk but where the consumer is not attempting harm to himself/herself.

**Significant Medication Error** - A significant medication error includes a missed medication, incorrect medication or incorrect dosage, where a consumer suffers an adverse consequence that is either short or long term in duration or receives treatment to offset the effects of the error.

Non-reportable events include:

• Refusal by the consumer to take prescribed medication.

**Any event requiring the emergency services of the fire department, or a law enforcement agency** – This includes events such as fires; an individual charged with a crime; an individual who is a victim of a crime; acts of violence; vandalism, or misappropriation of consumer property.

Non-reportable events include:

• Non-emergency services of the fire department or law enforcement agency.
• Police presence related to commitment procedures or rescue squad activities.
• Testing of alarm systems/false alarms, or 911 calls by consumers that are unrelated to criminal activity or emergencies.
• Presence of law enforcement personnel during any activity governed by the Mental Health Procedures Act.

**Abuse** – Allegations of abuse are to be reported. Abuse is occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse. For the purposes of this Bulletin, abuse includes abuse of consumers by staff or abuse of consumers by others. Depending on the nature of the abuse, it may also constitute a crime reportable to police. Abuse includes:

• **Physical Abuse** - An intentional physical act by staff or other person which causes or may cause physical injury to an consumer.
• **Psychological abuse** - An act including verbalizations, which may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean a consumer.
• **Sexual abuse** - An act or attempted acts such as rape, sexual molestation, sexual harassment and inappropriate or unwanted touching of a sexual nature of a consumer by another person. Any sexual contact between a staff person and a consumer is abuse.
• **Exploitation** - The practice by a caregiver or other person of taking unfair advantage of a consumer for the purpose of personal gain, including actions taken without the informed consent of the consumer or with consent obtained through misrepresentation, coercion or threats of force. This could include inappropriate access to or use of a consumer’s finances, property, and personal services.
Non-reportable events include:

- Altercations among residents that may result in physical contact but do not cause serious injury and which do not reflect a pattern of physical intimidation or coercion of a resident.
- Discord, arguments or emotional distress resulting from normal activities and disagreements that can be found in typical congregate living situations.

**Neglect** - Neglect is the failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law, contract or regulation. This can include the failure to provide for needed care such as shelter, food, clothing, personal hygiene, medical care, and protection from health and safety hazards.

**Injury or illness of a consumer** – Reportable injury includes those where the consumer requires medical treatment more intensive than first aid. First aid includes assessing a condition, cleaning a wound, applying topical medications, and applying simple bandages. Reportable illness includes any life threatening illness, any involuntary emergency psychiatric admission, or any illness that appears on the Department of Health’s List of Reportable Diseases (pursuant to PA Code, Title 28, Chapter 27), including those appearing on the DOH list as the subject of voluntary reporting by the CDC (reports are only needed when the disease is initially diagnosed).

Non-reportable events include:

- Scheduled treatment of medical conditions, on an outpatient or inpatient basis.
- Any voluntary inpatient admission to a psychiatric facility, or service at a crisis facility or psychiatric department of acute care hospitals for the purpose of evaluation and/or treatment.
- ER visits or inpatient admissions that result from a patient’s previously diagnosed, chronic illness, where such episodes are part of the normal course of the illness.
- ER visits where the visit is necessitated because of the unavailability of the consumer’s primary care physician.

**Missing person** – Providers are to report a consumer who is out of contact with staff without prior arrangement for more than 24 hours. A person may be considered to be in "immediate jeopardy" based on his/her personal history and may be considered "missing" before 24 hours elapse.

Additionally, it is considered a reportable incident whenever the police are contacted about a missing person or the police independently find and return the consumer, regardless of the amount of time he or she was missing.

**Seclusion or Restraint.** Providers are to report any use of seclusion or restraint as defined in MH Bulletin "OMHSAS -02-01 The Use of Seclusion and Restraint in Mental Health Facilities and Programs."
PROCEDURES:

Providers and counties are to follow the procedures outlined below in order to ensure consistent reporting and management of incidents.

A. PROVIDER PROCEDURES

Providers are to develop written policies and procedures for an incident management process which include the following:

1. Mechanism to ensure that consumers, staff and volunteers have proper orientation and training to respond to, document and report incidents.
2. Notification process for the family of the consumer, with the expressed consent of the adult consumer, obtained at the time of the incident (unless the consumer is physically unable to provide consent). If the consumer has an advance psychiatric directive regarding family contact, it should be respected unless the consumer directs otherwise at the time of the incident and clearly has capacity to make that decision.
3. Assurance the consumer and family member (with consumer’s consent) have the opportunity to provide verbal or written comment about the incident that is included in the incident report. The consumer and family should be provided information and assistance, if needed, with making internal and external complaints related to a reportable incident.
4. Mechanism to debrief the consumer, and with consumer permission, family member or contact identified by the consumer regarding the outcome of the investigation and to provide written notification on the closure of an incident investigation.
5. Process for the internal review and investigation of incident reports. The level and intensity of the investigation is based on the seriousness of the incident. In some cases, the information gathered during the completion of the incident report will constitute an adequate investigation. In other cases, further investigation may be necessary to adequately analyze the incident. Investigations may include collection of physical evidence, witness interviews, document review and or visual inspection of the incident location.
6. Procedure for review following the death of any consumer served in the program.
7. Process to review incidents and share information with staff and others, including direct care workers, consumers, family members and advisory groups regarding specific incidents or trends.
8. Procedures that assure compliance with all applicable laws, regulations and policies.
9. Process to analyze the causes and methods of prevention for any significant incidents which would include at a minimum any accidental death; injury resulting in a major, permanent loss of function in a consumer; significant assault including rape and abuse; and any other incident determined by the provider, county or OMHSAS to warrant this level of review.
10. Plan for trend analyses to identify individual consumer and provider program systemic issues.
11. An incident file within the agency that includes all documents related to the incident and the investigation.

B. COUNTY OFFICES of MENTAL HEALTH PROCEDURES

County offices of mental health are to develop written policies and procedures for an incident management process that include the following:

1. Review and approval of each contracted provider’s and/or behavioral health managed care organization’s (BH-MCO’s) policies and procedures relating to incident management.
2. Review of provider investigations and a process to initiate county investigations as indicated independently or in collaboration with OMHSAS.
3. Analysis and sharing of information with appropriate individuals.
4. Procedures for reviews to occur following the death of any consumer.
5. Monthly review of incident data, by individual consumer and program for trends in order to:
   a. Identify consumers at risk.
   b. Identify programs with significant incident trends.
   c. Assure provider and or BH-MCO compliance with plans of correction resulting from incident investigations.
   d. Assess providers’ and/or BH-MCO’s incident management and investigative processes.
   e. Follow up in writing with local program administrators when individual consumer or program issues are identified.
6. Response to concerns from consumers or their families about the reporting and investigation processes and results, including requests for county MH or OMHSAS investigations when needed.

REPORTING AND REVIEW:

Providers and counties are to create an administrative structure that is sufficient to implement the requirements of this Bulletin. Specifically, they are to:

1. Assign an individual with overall responsibility for incident management.
2. Ensure that staff, individuals and families are trained on incident management policies and procedures.
3. Assign roles within their organization for reporting and investigation of incidents.
4. Assure corrective action for individual incidents.

A. PROVIDER REPORTING AND REVIEW

Providers are to:

1. Identify an incident management representative with overall responsibility for incident reporting and management. The incident management representative receives reports of incidents and ensures that reports are
submitted on time as specified in this Bulletin and the providers approved policies. The incident management representative ensures the provider staff:

a. Take prompt action to protect the consumer’s health or safety.

b. Follow the OMHSAS reporting procedures to complete the initial incident report no later than 24 hours after the incident or no later than 24 hours after the provider learns of the incident.

c. Contact appropriate law enforcement agencies when there is suspicion that a crime has occurred.

d. Ensure investigation of the incident per provider policy. Any reportable incident may be investigated by the provider, county and/or OMHSAS. This investigation process in no way precludes investigations by law enforcement agencies.

e. Based on the outcome of the investigation, finalize the incident report, documenting results of any investigations and all actions taken to prevent recurrence of the incident.

f. Finalize the incident report within 5 working days of the incident for incidents that are readily investigated and resolved. In cases where further investigation of the incident is occurring, the provider should complete the report for review by the County MH office within 30 calendar days.

2. Identify a provider point person(s) who receives verbal or other reports or allegations of incidents from individuals, families and initial reporters. When an incident is reported, the point person, as a representative of the agency, is to:

a. Confirm that appropriate actions have been taken or order additional actions to secure the safety of the individual involved in the incident.

b. Separate the individual from the target when the individual’s health and safety may be jeopardized.

c. Determine follow-up that may be needed.

d. Secure the scene of an incident when an investigation may be required.

e. Notify appropriate supervisory/management personnel within 24 hours of the incident, as specified in provider/entity or county policies.

f. Initiate a HCSIS Incident Report within 24 hours as described in the Reportable Incident section of this bulletin.

g. Notify the family within 24 hours unless otherwise indicated in the individual care plan or advance directive, if applicable.

3. Implement a review process. It is recommended that providers dedicate time each day to review prior day incident reports to assure they are properly completed, make decisions on actions to prevent reoccurrence and establish closure on events not under investigation. Incident reports should be reviewed individually to determine if provider action has been appropriate and sufficient.

4. Analyze incidents which involves:

a. Analysis of the cause and methods of prevention for any significant incidents which would include at a minimum any accidental death; injury resulting in a major, permanent loss of function in a consumer; significant assault including rape and abuse; and any other incident
determined by the provider, county or OMHSAS to warrant this level of review.
b. Trend analyses to identify individual consumer and provider program systemic issues.
c. Analysis of quality of data on incidents and the quality of investigations.
d. Identification and implementation of individual and systemic changes based on risk management analysis.

B. COUNTY REPORTING AND REVIEW

Counties are to:

1. Identify an incident manager with overall responsibility for incident reporting and management. The incident manager is the person with overall responsibility for incident management within the county program. This responsibility includes a review to ensure incidents are managed and reported by provider or county staff in accordance with the process described in this statement of policy. The incident manager can approve or not approve HCSIS Incident Reports submitted by the provider or by a county point person.

2. Identify a county incident point person(s). The point person has the ability to initiate an incident that comes to the attention of the county and has not been reported by a provider. A point person cannot approve or not approve HCSIS Incident Reports.

3. Identify a county incident reviewer(s). The county incident reviewer has the ability to review incidents but cannot initiate or change incidents already entered into the system.

4. Implement a county process for the review and analysis of incident report data. This bulletin does not direct any specific procedure for this review or analysis. However, it is recommended that county MH staff dedicate time each day to do the following:
   a. Review prior day incident reports to assure they have been properly completed.
   b. Assure follow-up actions have been taken by the provider to protect the consumer and prevent reoccurrence of any incident.
   c. Assure that a thorough investigation has been conducted by the provider.
   d. Monitor incidents needing to be finalized by provider or county staff.
   e. Ensure final approval of HCSIS Incident Reports filed by the county.

5. Analyze incidents. The county incident manager should conduct regular trend analysis to provide the agency, the county and OMHSAS with insights into specific issues that cannot be gained from the review of individual incident reports. It should be conducted across individual program locations as well as across providers.

C. OMHSAS ROLE

The OMHSAS regional offices provide oversight of the process, including:
1. Review incident reports and final reports to assure that appropriate action and investigation of each incident is being conducted by the provider/county, with emphasis on the safety of the consumer.
2. Contact the county and provide direction when further investigation is warranted.
3. Review data to identify trends which may require administrative steps to support improved risk management.

The OMHSAS central office will review data on all reported incidents to identify any trends that may be developing statewide. OMHSAS will incorporate these findings into the Annual Quality Management Plan.
### OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE FIELD OFFICES

<table>
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| Office of Mental Health and Substance Abuse Services  
Norristown State Hospital  
Building 57 – Room 105  
1001 Sterigere Street  
Norristown, PA 19401-5397  
610 313-5844  
FAX 610 313-5845 | Office of Mental Health and Substance Abuse Services  
Scranton State Office Building  
Room 321  
100 Lackawanna Ave.  
Scranton, PA 18503  
570 963-4336  
FAX 570 963-3050 |
| Central                           | Western                                        |
| Office of Mental Health and Substance Abuse Services  
Harrisburg State Hospital  
Logan Building #12 - 2nd Floor  
2301 N. Cameron Street  
Harrisburg, PA 17110  
717 705-8396  
FAX 717 705-8386 | Office of Mental Health and Substance Abuse Services  
413 Pittsburgh State Office Building  
300 Liberty Avenue  
Pittsburgh, PA 15222  
412 565-5226  
FAX 412 565-5393 |
| Mailing Address:  
P.O. Box 2675  
Harrisburg, PA 17105 |
Pennsylvania Department of Health List of Reportable Diseases
(Title 28, Chapter 27)

1. AIDS (Acquired Immune Deficiency Syndrome).
2. Amebiasis.
3. Animal bite.
4. Anthrax.
5. Botulism.
7. Campylobacteriosis.
10. Cholera.
11. Diphtheria.
12. Encephalitis.
13. Food poisoning.
15. Gonococcal infections.
17. Haemophilus influenzae type b disease.
18. Hepatitis non-A non-B
19. Hepatitis, viral, including Type A & B
20. Histoplasmosis.
22. Legionnaires’ disease.
23. Leptospirosis.
24. Lyme disease.
25. Lymphogranuloma venereum.
26. Malaria.
27. Measles.
28. Meningitis – all types.
29. Meningococcal disease.
30. Mumps.
31. Pertusis (whooping cough).
32. Plague.
33. Poliomyelitis.
34. Psittacosis (Ornithosis).
35. Rabies.
36. Reye’s syndrome.
37. Rickettsial diseases including
   Rocky Mountain Spotted Fever.
38. Rubella (German Measles) &
   congenital rubella syndrome.
39. Salmonellosis
40. Shigellosis.
41. Syphilis – all stages.
42. Tetanus.
43. Toxic shock syndrome.
44. Toxoplasmosis.
45. Trichinosis.
46. Tuberculosis – all forms.
47. Tularemia.
48. Typhoid.
49. Yellow Fever.

Please note that the list of legally reportable diseases in Pennsylvania is subject
 to change (work is in progress to modify the regulation to match more recent
 public health policy and science). Also, please note that certain broad categories
 such as #13 (“Food Poisoning”), and #28 (“Meningitis - all types”) should be construed
to mean all such illnesses, even if the etiology is either not otherwise listed here, or a
specific etiology cannot be determined. Similarly, acute Hepatitis C infections should be
reported under the authority of #18 (“Hepatitis non-A non-B”), and Ehrlichiosis should be
reported under the authority of #37 (“Rickettsial diseases”). Finally, note that local
jurisdictions may require reports of additional conditions not listed here within their
jurisdictions.

In addition to the diseases listed above, CDC requests the voluntary reporting of either
laboratory identification of, or illness caused by the following pathological agents: (1) E.
coli O157:H7 and other verotoxin-producing (enterohemorrhagic) E. coli, (2) Cryptosporidium,
(3) Cyclospora, (4) Hantavirus, (5) Hemolytic uremic syndrome (a likely marker of infection with verotoxin-producing E. coli), (6) Invasive disease due to
Group A Streptococcus (such as necrotizing fasciitis, but not pharyngitis) and (7)
Listeria monocytogenes.
Victim’s Assistance Programs

When consumers are abused, neglected, injured or victims of crimes, there are resources to assist them physically, emotionally, financially and legally. Organizations have been developed based on the need to support victims through the criminal justice system, recognizing that victim’s needs are oftentimes overlooked. Consumers with disabilities who fall victim to crimes, especially physical violence and sexual assaults should be encouraged and assisted to access these resources. It is suggested that providers develop relationships with local entities and assist consumers in accessing such services when appropriate.

There are two main types of victim assistance programs: system and community-based organizations. System-based programs which generally operate out of a District Attorney’s office, provide notification to victims/witnesses of court proceedings. Community based programs are designed to provide support and assistance to victims. Usually, the programs fall under the categories of:

- Rape Crisis/Sexual Assault programs providing services to victims and their family/supporters. Domestic Violence programs provide counseling and temporary housing to victims, as needed.
- Crime Victim Services provide supports and assistance to victims of crimes excluding sexual assaults and domestic violence.

There are domestic violence centers, rape crisis centers and victim assistance offices throughout the Commonwealth. In order to locate the most appropriate resource for consumers, you may contact the following statewide organizations. Additional information regarding local resources is available through these organizations:

**PA Commission on Crime and Delinquency [PCCD]**  
(717) 787-2040

**PA Coalition Against Rape [PCAR]**  
(800) 692-7445  
(717) 728-9740

**PA Coalition Against Domestic Violence [PCADV]**  
(800) 932-4632

**Pennsylvania Protection & Advocacy, Inc. (PPA)**  
(800) 692-7443  
(717) 236-8110
GUIDELINES FOR CONSUMER/FAMILY SATISFACTION TEAMS AND MEMBER SATISFACTION SURVEYS

The Department of Public Welfare (DPW) values and encourages the input of consumers and families in all aspects of the HealthChoices Program and expects that such input will be incorporated in quality improvement. In addition the Office of Mental Health and Substance Abuse Services (OMHSAS) encourages input from consumers, persons in recovery, and families regarding the services and supports received in the mental health and drug and alcohol service system. Consumer and family feedback helps inform Providers, counties and Behavioral Health Managed Care Organizations (BH-MCO) about how services can support recovery for adults, resilience in children and adolescents and be more effective. Consumers and families have specialized knowledge and sensitivity about how respect, dignity and responsiveness of services can affect the process of recovery and preserve resilience. Members are more likely to feel safe in describing their experience with someone who is not their service Provider. Soliciting feedback on satisfaction with services empowers consumers and families and allows them to have a greater role in determining the quality of behavioral health care and recommending system improvements DPW therefore requires Primary Contractors to implement a comprehensive approach for the measurement of consumer/family satisfaction, including but not limited to:

- A Consumer/Family Satisfaction Team (C/FST) Program
- An Annual Mailed/Telephonic Survey of Member Satisfaction

A. CONSUMER and FAMILY SATISFACTION TEAM PROGRAM

1. Purpose

The purpose of the C/FST Program is to determine whether adult behavioral health service recipients and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner. Surveys should identify consumer and family member satisfaction with the services of a specific Provider as well as the level of satisfaction with the behavioral health system and all of the treatment, services and supports each consumer is receiving. This is primarily accomplished by gathering information through face-to-face discussions with Recipients of behavioral health services and the families of child and adolescent service Recipients, with follow-up reports, dialogue, and problem resolution feedback with the Primary Contractor.

It is the responsibility of the Primary Contractor (the Primary Contractor refers to the responsible party that holds the HealthChoices contract or agreement with DPW) to provide the support, encouragement, and resources necessary to build a
strong, independent, conflict free C/FST Program. In a recovery oriented service system support and encouragement would be evidenced by a Primary Contractor that:

- Communicates the importance of listening to and acting upon the results of satisfaction feedback from C/FSTs;
- Supports and encourages C/FSTs so that they are considered a respected and valuable service;
- Requires timely Provider action in response to survey results;
- Has a Provider network that works in partnership with C/FSTs to continuously improve service responsiveness using survey results in their internal quality management program;
- Identifies system improvement needed based on survey results;
- Actively provides direction and feedback to C/FSTs about how to improve their program and acquire the skills needed to move toward the independent operation of a satisfaction survey program; and
- Provides the resources necessary to accomplish the requirements outlined in this document.

2. Organizational Requirements of Consumer/Family Satisfaction Team Programs

In order to determine whether or not behavioral health services are meeting the needs and expectations of adults, young adults, children and adolescents and their family members, the Primary Contractor shall ensure that the C/FST Program is organized and operates in compliance with the following:

The Primary Contractor either directly, or via a BH-MCO or other sub-contractor, must have systems and procedures to routinely assess service Recipient satisfaction. The C/FST Program may be either a single or a multi-county program based upon the nature of the contract between DPW and the Primary Contractors. The family satisfaction component may be accomplished either as a separate administrative entity or as a component of the C/FST Program that is specifically responsible for family satisfaction activities.

(a) The Primary Contractor for HealthChoices and/or the BH-MCO must have a contract or a written and signed agreement with each C/FST Program and fiduciary, if applicable, that delineates roles and responsibilities of all parties. Designation of who holds the responsibility for advocacy and follow-up on behalf of Members should also be included.

(b) Under the contract or written agreement, and consistent with the requirements of the Mental Health Procedures Act (Chapter 5100), the C/FST members will act as agents of the Primary Contractor, and are, therefore, to have the same access to consumers and family members as the Primary Contractor and service Providers, insofar as it is necessary to perform their responsibilities.
(c) Each C/FST Program must have a Director who may be full or part time depending upon the size of the program. The Director must be a person who self-identifies as a consumer, person in recovery, or family member as stated in 3(a) and (b) as of January 1, 2005. If the current Director hired prior to January 1, 2005 does not meet this requirement, he or she may continue to serve until such time as the position is vacant and a new Director is hired.

(d) C/FST members must be paid at least as much as other persons in the general workforce doing similar work in the same community.

(e) C/FSTs must be independent from any Provider of behavioral health services or any other agency that might create a conflict of interest. C/FSTs that do not have accounting capabilities may contract with a provider as its fiduciary provided the contract safeguards the independence of the C/FST for program direction including budget priorities, satisfaction surveys, findings and recommendations.

(f) The Primary Contractor shall work with the C/FST to establish an annual plan for conducting face-to-face interviews. The plan will include goals such as: the number of interviews to be completed, the levels of care to be surveyed and special focus surveys to address specifically identified special populations. If the C/FST Program identifies barriers to accessing Members to be surveyed, the Primary Contractor will assist to resolve the issue. Priority populations should be given priority for face-to-face interviews.

(g) The Primary Contractor will ensure that the C/FST Program has adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports.

3. **Consumer and Family Satisfaction Team Minimum Requirements**

(a) Persons performing adult satisfaction activities must be, or have been, consumers of behavioral health services, persons in recovery, or family members.

(b) Persons performing family satisfaction activities must include family members of children and adolescents with serious emotional disturbance and/or substance abuse disorders who are receiving or have received behavioral health services in the publicly funded system, and may also include older adolescents and/or young adults who are receiving or have received behavioral health services as a child or adolescent in the publicly funded system.
(c) Family satisfaction team members must have child abuse and criminal history clearances in accordance with the Child Protective Services Law, Chapter 63, Sections 6303 and 6344, and are mandated reporters for child abuse.

(d) The family satisfaction component may be a separate and distinct administrative entity, or may be at least one team of a C/FST Program or one member of a team dedicated to family satisfaction activities.

(e) Young adults (18-22) may be interviewed by either consumer or family satisfaction team members, as appropriate, depending on the services being received.

4. **Conducting Satisfaction Surveys**

Consumer and family satisfaction interviews serve as a means for early identification and resolution of problems related to service access, and timeliness of service delivery, appropriateness of services and recovery and resilience outcomes. Face-to-face interviews afford Members the opportunity to communicate openly with peers on an on-going basis. Additionally, satisfaction surveys assist in determining the level of satisfaction with respect, dignity and hopefulness as integral components of the entire service delivery system. These activities also provide a further check to ensure that the service system is consistent with the principles of recovery in adults, resilience in children and adolescents, of the Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), cultural competence, and Drug and Alcohol (D&A) Treatment Principles. The Primary Contractor shall ensure:

(a) Consumer/family satisfaction should be assessed through face-to-face interviews with adult behavioral health service Recipients; children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families. Interviews should be face-to-face whenever possible however, telephone or mailed surveys may be used if preferred by the Member.

(b) The Primary Contractor shall establish mechanisms in their contract or written agreement to inform the C/FST Program of newly enrolled Members receiving behavioral health services and on-going Members who may wish to participate in satisfaction interviews. The first mechanism below is to be used when member names, addresses and telephone numbers are provided to the C/FST. The second mechanism describes the process if the Primary Contractor does not wish Member names to be provided to the C/FST without Member consent. It is the Primary Contractors responsibility to select the mechanisms for notifying Members about the C/FST Program as follows:

i) The Primary Contractor periodically provides the names and addresses of Members newly enrolled in mental health services to the C/FST and at
least annually updates the list for Members who continue to remain enrolled, and notifies Members receiving drug and alcohol services as stated in 4 (b) ii below; or

ii) The Primary Contractor informs all newly enrolled Members receiving mental health and/or drug and alcohol services about the C/FST Program. The names of members receiving mental health services who wish to be interviewed can be provided to the C/FST without a release of information. Members receiving drug and/or alcohol services must sign a release of information in order for their name, address and telephone number to be provided to the C/FST. A mechanism must be established to provide an opportunity to be interviewed at least annually for Members that remain enrolled in mental health and drug and alcohol services.

(c) Service Providers must provide C/FSTs with comfortable private space for interviews to ensure an environment in which behavioral health consumers and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families feel free to express any concerns they may have.

(d) C/FSTs solicit input from Recipients of behavioral health services and the families of children and adolescents receiving behavioral health services in order that satisfaction and areas of concern can be identified and recommendations for systems improvement can be developed. This can be accomplished through individual and/or group discussions, upon discharge from a service, and as focus groups with behavioral health consumers, persons in recovery, children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families, including visits to programs where members receive their services or to their homes. Family members may be more easily accessed when interviews are conducted by telephone. Information about the C/FST Program is best shared in face-to-face presentation with individuals or groups, however, such methods as videotapes, telephone or written material may also be used.

(e) Some of the C/FST survey questions should address satisfaction with the Provider(s) and the mental health and drug and alcohol service(s) the consumer is receiving. The findings of the C/FST shall be organized to identify the Provider, or special population in the case of a focused survey for three purposes: 1) to allow the managed care organization to include C/FST information in Provider profiling, 2) to provide feedback to the individual Provider about their program, and 3) to allow the Primary Contractor (County and/or Managed Care Organization) to direct the Provider to take corrective action to address a Member concern or concerns about the Provider operation or program. The face-to-face surveys and monthly problem solving process ensure action is taken on an ongoing basis and resolution for the Member is timely and responsive. Both the on-going surveys and the annual survey
describe in Section B can be used to identify trends that may require system improvement.

(f) The Primary Contractor will identify and request the C/FST to conduct outreach efforts to under-served or un-served groups of consumers and families in order to conduct satisfaction surveys and identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services.

5. **Areas for Consumer and Family Satisfaction Team Observation and Discussion with Recipients of Behavioral Health Services and the Families of Child and Adolescent Service Recipients**

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. The survey tool should allow identification of the Provider(s) and the service(s) provided as well as general satisfaction with the service system. Satisfaction surveys shall include but not be limited to the following areas:

**BH-MCO Related Issues:**
- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

**Service Delivery:**
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

**Treatment:**
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
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- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care

Overall Satisfaction:
- Degree to which services were consistent with CSP, CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

DPW may from time to time require specific questions to be added to C/FST satisfaction surveys in order to conduct statewide quality assurance activities.

6. Confidentiality

All employees of C/FST Programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services. The contract or written agreement will address confidentiality requirements including the following:

(a) All C/FST members must receive training in confidentiality regulations for mental health and substance abuse services. All family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services.

(b) All C/FST members must sign a confidentiality agreement, and personnel policies must address disciplinary procedures relevant to violation of the signed confidentiality agreement.

(c) Mental Health Confidentiality: For purposes of the HealthChoices program, C/FSTs are agents of the Primary Contractor, and have the delegated authority to collect and disseminate the needed information. C/FST members must be considered as equal to all other mental health professionals with regard to access to mental health consumers, children and adolescents with serious emotional disturbance and their families. There should be no special written permission required to engage consumers and families receiving mental health, whether in state hospitals or community programs.
(d) Mental Health Confidentiality: If the Recipient of mental health services is a child (up to 14 years of age), he or she may be interviewed but only in the presence of a responsible family member or authorized caregiver, and the family member or caregiver must also be interviewed. If the Recipient of mental health services is an adolescent (14 to 18 years of age), the adolescent should be interviewed independently and responsible family members or an authorized caregiver could also be offered the opportunity to be interviewed. It is preferable but not necessary to receive the adolescent’s consent before interviewing family members or caregivers.

(e) Drug and Alcohol Confidentiality: A service agreement between the C/FST Program and each Drug and Alcohol Provider outlining Drug and Alcohol confidentiality rules, rights, regulations and laws that govern Drug and Alcohol Providers in Pennsylvania is also required. This is consistent with the current practice of Drug and Alcohol Providers to require such an agreement be signed by representatives of the Departments of Health and Public Welfare, Joint Commission on Accreditation of Healthcare Organizations, and Single County Authorities for Drug and Alcohol services.

(f) Drug and Alcohol Confidentiality: Prior to a drug and alcohol service Provider contacting a C/FST Program to provide the name of a person who wishes to be surveyed, a consent to release information form must be signed by the Member requesting their name, address and telephone number be provided to the C/FST Program. A copy of the signed consent to release information form must be retained in the Member’s treatment file and a copy given to the Member and the C/FST. Consent to release information forms for Members receiving drug and alcohol treatment services are not required when the C/FST conducts surveys without receiving the persons name and reports data in the aggregate.

(g) Drug and Alcohol Confidentiality: Recipients of drug and alcohol treatment services, regardless of age, must give their written consent for a parent or other family member to be interviewed, or to be present while the Recipient of services is being interviewed.

(h) C/FSTs must be afforded the opportunity to meet with mental health consumers and Recipients of substance abuse services and the family members of child and adolescent service Recipients to describe and explain the purpose and function of C/FSTs.

7. **Problem Identification and Recommendations for Action**

C/FSTs must provide feedback to the Primary Contractor through written quarterly reports and monthly problem resolution meetings that allow for dialogue and review of findings. The Primary Contractor is responsible for timely reports back to the C/FST on specific actions and problem resolution resulting from identified issues, concerns and problems. The contract or written agreement shall
identify the process the Primary Contractor will use to resolve problems and address suggestions identified by the C/FST including the following:

(a) Process for problem identification and resolution that includes the C/FST Program, consumers, persons in recovery, parents, adolescents, children, designated county staff, staff of the managed care organization, and advocates as appropriate to the problem identified.

(b) The problem resolution process must include how often problem resolution meetings will occur, with whom, and the responsibilities of all parties (County, C/FST, managed care organization, and Providers). This process will identify actions to be taken by the Primary Contractor if resolution is not reached. There must also be a process in place for responding to urgent matters identified by Members.

(c) The Managed Care Organization sub-contracts with Providers of behavioral health services in their network shall include the timeframe in which the Provider must respond to the recommendations made by the C/FST as directed by the County, Managed Care Organization or the C/FST. Providers of behavioral health services should be required to use C/FST feedback in their quality management program.

(d) The Primary Contractor must provide a timely response to the C/FST on actions taken in response to reported problems and concerns resulting from service Recipient interviews for inclusion in the next quarterly report.

(e) Mechanisms must be in place to address identified trends or system changes that may require the Primary Contractor to study in more depth to understand the issue and resolve. This may include focus meetings on specific topics or collaboration with other involved service systems. The results of these focus studies will be provided to the C/FST for inclusion in their reports.

8. Knowledge, Training and Orientation of Consumer and Family Satisfaction Teams

The Primary Contractor will ensure that C/FST members have both an initial orientation to and on-going training in the following areas:

(a) C/FST members must have basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both for adults and children and adolescents. Persons performing Family Satisfaction activities must also have an understanding of serious emotional disturbance and substance abuse disorders in children and adolescents.
(b) Training for C/FST members must include confidentiality regulations for mental health and substance abuse services. Family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services. Training must include an understanding of responsibilities, as applicable, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(c) C/FST members must also have an understanding of the cultural diversity of the individual and community being served in order to ensure culturally sensitive interactions. Training shall include the basic concepts of recovery and resilience.

(d) Family satisfaction team members must have training in the responsibilities of being mandated reporters for child abuse.

(e) The Primary Contractor shall arrange a minimum of two (2) hours orientation/training on the BH-MCO operations, policies and procedures for satisfaction team members.

9. Quarterly Reports

The Primary Contractor shall provide the Department with the C/FST Program’s quarterly report summarizing consumer and family satisfaction findings, as well as improvement actions and system changes implemented by the Primary Contractor in response to those findings. The Primary Contractor shall provide support and direction to the C/FST to ensure the report contains not only the numeric results of surveys conducted but also information about the actions taken in the previous quarter by the Primary Contractor or behavioral health service Provider, trends observed, and other relevant information that can be used by Providers and others about ways to improve treatment and supports.

10. DPW Annual Review of Consumer/Family Satisfaction Team Programs

DPW will conduct an annual review of the C/FST program that will include a review of the following:

(a) Results of satisfaction surveys;

(b) Actions taken to resolve identified issues and system changes;

(c) Role and effectiveness of the Primary Contractor in problem resolution and direction to the C/FST program;

(d) Adequacy of the budget, staff, and training opportunities to carry out the requirements of the program;
(e) Role of the fiduciary, if applicable, in supporting the program and financial priorities established by the C/FST program; and

(f) Progress on gaining skills and abilities of the C/FST program to move toward operating as an independent, conflict free, satisfaction program, as applicable

B. ANNUAL MEMBER SATISFACTION SURVEYS

1. Consumer and Family Satisfaction Annual Mailed/Telephonic Survey

The Primary Contractor is responsible for ensuring that an annual satisfaction survey of a representative sample of persons served by the behavioral health program is conducted by mail or telephonically. The purpose of the Annual Mailed/Telephonic Consumer and Family Member Satisfaction Survey is to determine the extent to which the BH-MCO adult Members and family members of children and adolescents are satisfied with overall BH-MCO operations and services, and to identify areas which need improvement. Surveys are developed and used by the BH-MCO to gather information to determine whether the BH-MCO adult Members and family members of children and adolescents are knowledgeable about and satisfied with the behavioral health program including core functions such as member services as well as to assess whether service availability, service access, and services provision and effectiveness are meeting the Member’s needs and expectations.

(a) Surveys of Recipients of substance abuse services, regardless of age, must be distributed by Providers at service delivery sites in order to protect the confidentiality of persons being surveyed.

(b) A separate survey instrument must be developed for children and adolescent service Recipients and their families.

(c) Findings and resulting recommendations from the survey and consumer/family satisfaction activities are to be incorporated into the Primary Contractor’s ongoing quality management and improvement program.

(d) The County may directly conduct the annual survey or direct the managed care organization, C/FST Program, or another entity that would be conflict free, to conduct the annual survey.

2. Areas Covered by the Consumer and Family Satisfaction Survey
Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. Satisfaction surveys shall include but not be limited to the following areas:

**BH-MCO Related Issues:**
- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

**Service Delivery:**
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

**Treatment:**
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family Members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care

**Overall Satisfaction:**
- Degree to which services were consistent with CSP, CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

**Miscellaneous:**
- Items required by the Department as a result of the Department’s ongoing monitoring and program evaluation.
- Knowledge of and satisfaction with the Medical Assistance Transportation Program
➢ Satisfaction of consumers with special needs e.g. deaf and hard of hearing, older adults, people who are homeless, etc.
➢ Suggestions for improvement

3. **Sampling Procedure**

The Annual Mailed/Telephonic Consumer and Family Satisfaction Survey must be sent to, or conducted with, a representative sample of behavioral health service Recipients with a statistically valid sampling of Members in the adult priority population groups, family members of child and adolescent service Recipients, and special needs populations, as well as a sampling of Members who filed complaints and grievances. The survey of Members receiving drug and alcohol services must be anonymously distributed through service Providers.

4. **Frequency of Survey and Reporting Results**

A report of the survey findings and resulting recommendations for quality improvement must be submitted to the Department as part of the annual quality management summary report, quality management plan for the upcoming year. The Consumer and Family Satisfaction Mailed/Telephonic Survey will be conducted at least annually.