Nebraska Registered Service Provider's

Program Plan for the Delivery of Treatment Services

Purpose of a Program Plan

A Program Plan is a management document to assist with organization and to ensure consumers accomplish desired outcomes. Program Plans are used in determining whether a potential vendor/contractor has the capacity to serve consumers, achieve outcomes for a purchased service, and has policies, procedures and processes in place to begin service. The Program Plan should be written as if the target audience was staff, consumers, and members of the public.

Consumer Participation

There should be a mechanism for meaningful participation of consumers in the development, evaluation, and ongoing updates of a Program Plan.

I. Program Plan Content

A. Program Overview

This section should contain all of the following:

1. The program's mission
2. The program's philosophy
3. Goals, objectives and specific outcomes
4. Description of the treatment modalities to be provided to achieve the program objectives and meet client needs
5. Population served, to include information about:
    a. Age (children, adolescents, older adults; specify age ranges)
    b. Sex
    c. Gender (specifically women's issues)
6. Special populations served
    a. for example: physical or cognitive disabilities, co-occurring substance use and mental disorders, rural populations, HIV positive, homeless, veterans, race and ethnicity, sexual orientation, criminal justice population.
7. Settings (i.e., description, addresses, phone and fax numbers)
8. Days of operation
9. Hours of operation
10. Frequency of services
11. Payer sources
12. Fees
13. Estimated length of stay for a consumer to successfully complete the program
14. Description of how the program includes evidence-based practices
15. Describe how program activities are designed to the specific needs of the program's consumers
16. Procedures for documentation, such as:
    a. Progress notes and other relevant records include:
        1) Progress towards identified goals and objectives
        2) Significant events in the person's life
        3) Changes in frequency of services and levels of care
    b. All documents generated by the organization include original (or electronic signatures), are signed, and are dated

B. Client Rights and Responsibilities, Grievance and Complaints

This section should contain all of the following:

1. Consumer Rights document with an all-inclusive list of rights

a. Rights should be written in language understandable to consumers and families.
b. The consumer should receive a copy of the Consumer Rights document
c. Date and duration of session/service and modality.

2. Procedures for informing consumers of rights
3. Addresses therapeutic consumer/staff relationships
4. System for reporting, investigating, and resolving allegations of abuse, neglect and exploitation
5. Complaint and Grievance procedure and documentation of actions taken toward resolution

C. Screening and Admission Criteria

This section should contain all of the following:

1. Screening process; implementation of procedures for:
   a. If/How screening is conducted and by whom
      1) Screening should include (and be documented):
         a) Presenting problem
         b) Referral source
         c) Urgent and immediate needs
         d) Legal status
         e) Funding source
         f) Whether the organization can provide the needed services based on appropriateness and eligibility criteria
2. Admission criteria
   a. Appropriateness and eligibility criteria
      1) Must not exclude persons solely on the basis of previous admission record, marital status, race, sexual orientation, color, national origin, religion, or disability without adequate referral to appropriate services
      2) Restrictions (such as age, gender, etc.) must be clearly stated and justified in the program plan.
   b. Level of treatment recommended
3. Description of specific admission processes with policies and procedures, to include:
   a. How admissions are conducted
   b. Who is responsible for making admission decisions

D. Assessment

This section should contain all of the following:

1. Procedures that describe the assessment and information gathering process, including:
   a. A description of how consumers, families, and others with collateral information are involved in the assessment
   b. Identification of who is qualified and responsible to perform assessments
   c. List of all screenings, tools, and evidenced base practices
   d. A description of the system of referral to alternative services for those clients who do not meet admission criteria. (Referrals must be documented.)
2. Assessments should be strength-based and include the following (at a minimum), in accordance with the Standardized Model format:
   a. Demographics
      1) includes age, sex, sexual orientation, gender, gender expression, marital status, spirituality, culture, housing, transportation, insurance
   b. Presenting Problem / Primary Complaint
   c. Medical History
   d. Work / School / Military History
   e. Alcohol / Drug History Summary
   f. Legal History
   g. Family / Social Peer History
   h. Psychiatric / Behavioral History
      1) Trauma History

a) i.e., abuse/neglect, witnessing violence, natural disasters
b) When assessing trauma, the provider will provide appropriate intervention if needed and within the provider's scope of practice. (Referrals will be provided as necessary.)

l. Collateral Information
j. Other Diagnostic / Screening Tools – Score and Results
k. Clinical Impression
l. Recommendations
m. Attachment A: Pertinent Biopsychosocial Information

3. Referral mechanism and coordination with external providers when needs are identified
4. Specific time frames for assessments, reassessments/evaluations

E. Orientation

This section should describe the following:

1. Time frame for orientation
2. How the consumer/family are oriented to the program following admission
3. Describe the systematic approach for keeping consumers involved and providing opportunities for feedback through out all phases of the program
4. Documentation of an orientation that is understandable to the client and includes (at a minimum):
   a. Explanation of rights and responsibilities
   b. Notice of privacy practices (includes confidentiality)
   c. Complaint and appeal procedures
   d. How input can be given
   e. Consent to treat
   f. Intervention regarding danger to self, others, and abuse (i.e., mandatory reporting)
   g. Access to after hours services and crisis intervention services
   h. Financial obligations
   i. Program policy regarding alcohol, drugs, prescription medication, weapons, violence
   j. Program policy regarding alcohol and drug use while participating in treatment services
   k. Conditions for administrative discharge
   l. Assessment process
   m. Transition and discharge criteria
   n. How the service (i.e., treatment) plan will be developed
   o. Explanation of provider collaboration with partnering agencies (e.g., behavioral health, criminal justice, medical, child welfare)

F. Treatment Plan

This section of the program plan should describe how the treatment plans in this organization contain the following key elements:

1. Description of the treatment planning process and written procedures
   a. Treatment planning is based on the client's strengths, and problems, abilities, identified in the assessment process
      1) For the criminal justice client, incorporates the elements of the Standardized Model, screening, and assessment tools
   b. Identification of the person(s) responsible for service/treatment planning
   c. Time frames for development and revision of the service/treatment plan
   d. Consumer and family participation
   e. Coordination of care to include (at minimum) staff, consumers and/or families, and criminal justice professionals as appropriate
2. Each treatment plan should include:
   a. Identified problem statement(s), goals, objectives, and interventions specifically related to criminogenic risks (including substance use), identified needs, and

strengths.
   1) Objectives are measurable, achievable, and have established time frames (i.e., a specific date)
   2) Interventions related to the accomplishment of the goal/objective which include a frequency
b. Crisis/Relapse/Safety plans are developed and included, as applicable and within the provider's scope of practice. (Referrals will be provided as appropriate.)
c. Treatment objectives for special populations served

G. Transition and Discharge Planning

This section should contain all of the following:

1. Transition and discharge criteria:
   a. Criteria should indicate when and how transition and discharge will be determined
   b. Observable criteria, consistent with the program's purpose
2. Policies and procedures describing specific transition and discharge processes that include:
   a. Specific time frames for transition and discharge planning and discharge summaries
   b. Transition planning should begin upon admission
   c. Identification of who is qualified and responsible for transition discharge planning and summaries
   d. Referral mechanism and coordination with other programs in transition and discharge planning
   e. Description of how consumers, families, and others are involved in transition and discharge planning
   f. How the transition and discharge plans are incorporated into a consumer's treatment plan
   g. Authorization to release and exchange information
3. Transition and discharge plans should include:
   a. Crisis/relapse plan including triggers and interventions
   b. Plan for follow-up, continuing care, services
   c. Consumer's plan to further his/her recovery
4. Discharge summary description should include:
   a. Admission and discharge dates
   b. Reason for discharge
   c. Describes the services provided
   d. Diagnosis
   e. Consumer progress in relation to the treatment plan (i.e., identified goals and objectives)
   f. Medications prescribed upon discharge (if applicable)
      1) Indicate how medications will be obtained following discharge (if applicable) and the identified provider
   g. Referrals and recommendations
   h. Time frame for completion of discharge summary

H. Outcomes

This section should include all of the following:

1. How the organization is collecting outcome measures.
2. Implementation of a performance improvement plan based on the outcome measure.
   a. This could include client satisfaction survey, agency satisfaction survey, discharge planning satisfaction survey, outcomes measures.

II. Annual Review of the Program Plan

Review of the plan should be conducted at least annually and as necessary to accurately reflect the services provided and dated.