

STATE OF CONNECTICUT
ACCESS TO RECOVERY II PROGRAM (ATR II)
Department of Mental Health and Addiction Services

ACCESS TO RECOVERY II

PROVIDER MANUAL

VERSION I

ATR II Administrative Services Organization
ADVANCED BEHAVIORAL HEALTH
www.abhct.com

STATE OF CONNECTICUT
ACCESS TO RECOVERY II PROGRAM (ATR II)
Department of Mental Health and Addiction Services

TABLE OF CONTENTS

SECTION	PAGE
General Information	1
What is Access to Recovery?	1
Program History.....	1
Connecticut’s ATR Program	1
Customer Service Information.....	1
Services	2
Clinical Services	2
Recovery Support Services.....	2
Provider Certification and Contracting Process	2
Recipient Eligibility	3
Voucher Management System	3
Application for ATR II Services	3
Application Instructions.....	3
Service Authorization	3
Discharges.....	3
Providing Basic Needs.....	4
Claims/Invoices	4
Recipient Grievances	4
Provider Grievances.....	4
Service Documentation.....	4
Ethics	5
Recipient Information and Confidentiality	5
Government Performance and Results Act (GPRA) Assessment	5
Site Visits and Quality Management	6
Site Visits.....	6
Fraud, Abuse and Waste	6
Appendix 1	
Code of Ethics for Prevention/Recovery Professionals	8
Appendix 2	
Privacy Rule of Health Insurance Portability and Accountability Act	10
Appendix 3	
Provider Training.....	11

GENERAL INFORMATION ABOUT ACCESS TO RECOVERY

Adapted from the Substance Abuse & Mental Health Services Administration (SAMHSA) Access to Recovery (ATR) website, <http://atr.samhsa.gov>

WHAT IS ACCESS TO RECOVERY?

ATR is a three-year grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). ATR is a presidential initiative which provides vouchers to adults with substance use disorders to help pay for a range of community-based clinical treatment and recovery support services. The goals of the program are to expand capacity, support client choice, and increase the array of faith-based and community-based providers for clinical treatment and recovery support services. All services are designed to assist recipients remain engaged in their recovery while promoting independence, employment, self-sufficiency, and stability.

PROGRAM HISTORY

The program was launched in August 2004 when three-year *Access to Recovery I* grants were awarded to 14 states and one tribal organization. During that grant period, more than 170,000 people with substance use disorders received treatment and/or recovery support services—exceeding the nationwide target of 125,000 people.

Given that success, the program was re-funded in September 2007 when three-year *Access to Recovery II* grants were awarded to 18 states, 5 tribal organizations, and the District of Columbia.

CONNECTICUT'S ATR PROGRAM

The Department of Mental Health and Addiction Services (DMHAS) received an *ATR I* grant in 2004 and an *ATR II* grant in September 2007. The program serves adults with substance use disorders who are involved with specific state and community partner agency programs. Advanced Behavioral Health (ABH) has been contracted by DMHAS to act as the Administrative Services Organization (ASO) for ATR II.

CUSTOMER SERVICE INFORMATION

Customer service representatives are available to answer general program questions and help with application processing, Monday through Friday 8:30 am – 5:00 pm.

Program Phone #: 1-866-580-3922

Program Fax #: 1-866-580-4322

Advanced Behavioral Health, Inc.
213 Court Street
Middletown, CT 06457
www.abhct.com

Department of Mental Health and Addiction Services
410 Capitol Avenue
P.O. Box 341431
Hartford, CT 06134
www.ct.gov/dmhas

SERVICES

In ATR II, recipients are able to choose services and service providers. Once requested and approved, services are issued as pre-approved vouchers. The following services are available in ATR II:

CLINICAL SERVICES

Buprenorphine Treatment Services: intended for individuals who are addicted to opiates. Suboxone, which contains buprenorphine and naloxone, is administered; a combination of clinical and medication services enables the recipient to become opiate-free between 181 and 365 days.

Co-occurring Enhanced Residential Treatment: is a short term residential treatment program designed to provide intensive services for individuals who are experiencing difficulties stabilizing their substance use and mental health disorders. The length of stay is approximately 30 days.

Co-occurring Intensive Outpatient Treatment: comprehensive services for individuals who have co-occurring substance use and mental health disorders; services assess and address both disorders.

Clinical Recovery Management Check-ups: intended for individuals who have completed Intensive Outpatient Treatment or Outpatient Treatment (IOP or OP); involves a weekly “check-up” call or meeting with staff to make sure the person is engaged in his/her recovery process.

RECOVERY SUPPORT SERVICES

Case Management: provides linkages to integrated clinical substance use treatment and recovery support services. Case management assists the individual in relapse prevention, obtaining gainful employment, and locating housing and other recovery supports in his/her community.

Faith-Based Services: support groups and/or individual meetings that help persons in recovery forge supportive connections with self-selected faith communities, discover positive personal interests, and take on valued social roles.

Peer-Based Services: include mentoring and coaching; engagement in recovery services and other positive activities; promoting constructive family and personal relationships; assistance in mapping and connecting with community resources; and assistance in securing transportation, housing, education and employment.

Certified Sober Housing: dwelling in which individuals in recovery reside as a supportive group and follow rules set forth by an owner or manager in an effort to support one another.

Independent Housing: dwelling in which an individual resides and has a signed lease stipulating use and occupancy.

Basic Needs: food, clothing, personal care items, and transportation assist recipients so they can focus on recovery.

Vocational/Educational Services: provide the training or classes needed to secure or increase employment.

Detailed services information can be found on the ABH website at www.abhct.com: Resources: ATR II: General Program Information: “Clinical and Recovery Support Services Authorizations.”

PROVIDER CERTIFICATION AND CONTRACTING PROCESS

All ATR II service providers must complete the certification and contracting process set forth by DMHAS and ABH. Providers will not be reimbursed for services until a contract has been executed. DMHAS and ABH retain the right to deny provider certification and contracting based on the information contained in the certification application or the current needs of ATR II.

RECIPIENT ELIGIBILITY

The ATR II target population is adults (18 years old or older) with a verifiable substance use disorder who are involved in one of several community-based or state agency programs at intake. ABH is required to verify the recipient's participation in one of these groups before approving services. The complete list of ATR II target populations is available on the "ATR II Fact Sheet", which can be accessed at www.abhct.com: Resources: ATR II: General Program Information or www.ct.gov/dmhas/atr.

VOUCHER MANAGEMENT SYSTEM

ATR II utilizes a web-based voucher management system (VMS) to collect and manage provider and recipient information. All application materials, with the exception of those documents that require the recipient's signature, must be completed online. Providers will use the VMS to input application information, including the Government Performance and Results Act (GPRA) assessment, request services, submit invoices, and discharge recipients. The VMS also provides information to providers such as: authorization determinations, GPRA assessments due, and payment status. Training on the Voucher Management System will be provided by ABH to certified providers. Detailed instructions on the VMS can be found at www.abhct.com under Resources: ATR II: General Program Information: "ATR II Web Manual."

APPLICATION FOR ATR II SERVICES

APPLICATION INSTRUCTIONS

Once the ATR II application is completed via the VMS, the provider will be prompted to fax documents requiring the recipient's signature to ABH (Release of Information, Consent to Participate, and Authorization to Disclose Last Known Address) to complete the application process. Application materials, including the GPRA assessment, are time sensitive. Providers must utilize the following guidelines when requesting services:

- Applications for initial service requests must be submitted online no later than 7 days after the GPRA assessment is conducted.
- Initial services must start no later than 7 days after the GPRA assessment date. Initial requests cannot include vocational, educational or independent living services.
- The requested service start date must be equal to or after the GPRA assessment date, but not later than seven days.

SERVICE AUTHORIZATION

ABH will complete determinations (approve or deny applications) within five business days from the date a complete application is submitted. Providers can view the status of the application at any time using the online system.

Any application received that is missing information will be pended for five business days from the time it is reviewed, to allow the provider time to submit the required information. These requests will show in the online system as "missing information", with a note of what is needed to complete the determination and the date the information is due (e.g., : Missing Info- signed ROI- due by 6/25/09). When all information is received and the determination is complete, the request will show as approved or denied. All denials will state the reason(s) for denial (e.g., unable to verify portal, duplicate application). Denials may be reversed if missing information (e.g., missing ROI or signed consent form) is submitted in a timely fashion.

DISCHARGES

ATR II Providers are required to discharge recipients:

- Who have not shown up for services in 90 or more days;
- Who have successfully completed services authorized;
- Who have requested to transfer to another provider of the same services;

- Who leave services against the advice of the provider; or
- Who become incarcerated.

A discharge must be entered online and is discussed further in the web-based voucher management system training manual located at www.abhct.com under Resources: ATR II: General Program Information.

PROVIDING BASIC NEEDS

Basic needs vouchers are generated daily and are mailed to the requesting provider. It is the responsibility of the requesting provider to distribute the vouchers and bus passes to the recipients. For further guidance on basic needs vouchers, please see go to www.abhct.com under Resources: ATR II: General Program Information: “Voucher Instructions for Providers who Request Vouchers.”

CLAIMS/INVOICES

Process: Invoices for authorized services must be submitted via the web-based voucher management system. Instructions on invoicing are listed in the Voucher Management System Manual located at www.abhct.com under Resources: ATR II: ATR II Web Manual. Checks are typically generated weekly and are mailed directly to the provider of services.

Deadline/Timely Filing: Providers must submit claims for payment no later than 30 days following the service date. **Claims received by ABH after the 30 day timely filing limit will be denied.** ABH has 30 days to pay a clean claim.

If a service or a claim has been denied, call the ATR II Call Center, (866) 580-3922, to request an explanation.

RECIPIENT GRIEVANCES

Recipient grievances are defined as a complaint against an ATR II provider. A recipient receiving ATR II services has a right to submit a grievance without fear of penalty or loss of services. Should a recipient have a grievance regarding services received via the ATR program, all efforts shall be made to resolve the grievance via the provider agency’s grievance procedure. If the grievance cannot be resolved at the provider level, then the recipient is encouraged to call the ATR II toll-free number. All complaints received by ABH will be documented and investigated. DMHAS will be informed of all documented grievances, investigation results, and grievance resolutions.

Corrective Action may be requested as a result of a complaint. ABH will set time frames and confirm completion of all implemented corrective action plans. If a grievance is received that may impact the health and welfare of an ATR recipient, DMHAS and/or law enforcement officials may be contacted immediately.

PROVIDER GRIEVANCES

ABH aims to provide the best customer service possible for ATR II providers but appreciates that there may be instances of miscommunication or other issues that need to be resolved. Providers are encouraged to raise issues verbally or in writing. Providers may file grievances with the ATR II Program Manager or request to speak with the Vice President of Programs at ABH. Providers also have the option of filing a complaint with the ATR II Program Manager at DMHAS.

SERVICE DOCUMENTATION

As an ATR II service provider, you must maintain hard-copy (paper) files for each recipient approved for services. Files must be:

- Individualized to each recipient and only contain information for one recipient;
- Kept in a secured location to which only approved staff have access;
- Kept at the service location approved for services in the ATR II service rate schedule; and
- Kept by the provider for a period of three years following the end of the contract term.

Sample documents and instructions on completing the documents can be found on the ATR II website at www.abhct.com under Resources: ATR II: Forms. Providers are not required to keep a copy of documents that are entered into the web-based voucher management system.

ETHICS

To help ensure that recipients of Access to Recovery services receive the highest possible quality of care, ATR II providers should adhere to the code of ethics listed in Appendix 1 or formulate a corresponding code for their agency.

RECIPIENT INFORMATION AND CONFIDENTIALITY

It is the expectation of ABH and DMHAS that providers will honor Federal HIPAA confidentiality requirements (see a summary in Appendix 2) and that by doing so, a provider will ensure that:

- only approved staff have access to recipient information;
- recipient information will not be shared with other parties without the proper release(s) of information;
- the expiration date and approved parties stipulated on the recipient's release(s) of information will be honored, and when communicating with approved parties, the recipient's information will be protected;
- releases of information are not altered by anyone but the recipient;
- recipient personal health information will not be sent over e-mail;
- communications that include recipient information will only be sent by secure fax or voicemail; and
- mailings sent to the recipient at his or her home do not reveal protected health information.

Providers may communicate with ABH by e-mail using the recipient's ATR II ID or Encounter number. Providers may not use recipient names or social security numbers in any e-mail.

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA) ASSESSMENT

The Government Performance and Results Act of 1993 was enacted by Congress to improve stewardship in the Federal government and to link resources and management decisions with program performance. All of the Center for Substance Abuse Treatment (CSAT) discretionary programs must comply with GPRA.

ATR providers must conduct the GPRA assessment at intake, six (6) months post-intake and at discharge from ATR II. ABH must receive GPRA assessments from at least 80% of ATR II recipients. Each of the three interviews is submitted via the web-based voucher management system. The ATR II goal is that each service recipient will show improvement—when the final GPRA assessment is compared to the initial GPRA assessment—in areas such as drug use, employment, social connectedness, and housing.

If a provider experiences difficulty in collecting a follow-up GPRA assessment, they should call the ATR II toll-free hotline as soon as possible to speak with a GMS (GPRA Management Support) staff member. GMS staff can assist in locating a recipient and obtaining a follow-up GPRA assessment. Upon successful completion of the follow-up GPRA assessment, the applicant receives a gift card valued at \$20 to be mailed to the address of his/her choice. Providers are required to conduct a six-month follow-up assessment even if the recipient has been discharged from the provider's services.

For a detailed description of the GPRA requirements, see "General Information" on the CSAT-GPRA website (www.samhsa.gpra.samhsa.gov). Detailed instructions on completing the GPRA assessment can be found at www.abhct.com, under the Resources: GMS and GPRA Information: "Question by Question GPRA Instruction."

SITE VISITS AND QUALITY MANAGEMENT

SITE VISITS

Provider site visits will be conducted throughout the duration of the ATR II program. Site visits may be performed at varying intervals, to evaluate the quality and appropriateness of services provided, recipient records, and professional conduct.

FRAUD, WASTE AND ABUSE

Documented incidents of alleged or suspected fraud, waste or abuse will be investigated by ABH, DMHAS, and law enforcement authorities as appropriate, according to state and federal guidelines. Recipients determined to have intentionally committed fraud, waste or abuse may be prohibited from receiving additional program services and may be reported to the appropriate law enforcement entity. Any provider determined to have knowingly committed fraud, waste or abuse shall risk ATR II contract termination. Please refer to the ATR II Provider Agreement for other situations under which the ATR II contract may be terminated.

For the purposes of ATR II, fraud, waste and abuse are defined as follows:

Fraud: includes, but is not limited to, intentional deceptions or representations that a recipient and/or provider knows to be false or does not believe to be true. The individual and/or agency makes deceptions or misrepresentations solely for the benefit of that individual/or agency. *Examples: knowingly billing for services that were not rendered, knowingly billing multiple times for the same services, knowingly billing multiple funding resources for the same services, misrepresenting agency or staff qualifications to deliver services, a recipient permits another person to use his or her voucher.*

Abuse: includes, but is not limited to, a provider acting in a manner that goes against sound clinical, financial, or business practices that results in the potential for recipient harm or unjustifiable program cost increases. It also includes recipient behaviors that generate waste of ATR II resources or unnecessary costs. *Examples: referring consumers to services that are not indicated during their assessment, continuing to refer consumers to services that are no longer appropriate, a recipient who continually requests provider changes without valid reasons.*

Waste: includes, but is not limited to, circumstances when services are not rendered or recipient outcomes are not fulfilled in a cost-effective manner. These circumstances may occur due to fraud or abuse. *Examples: rendering services when they are no longer necessary for a consumer's well-being or failing to bill other funding resources when appropriate.*

To prevent fraud, waste and abuse:

Provider responsibilities include, but are not limited to, the following:

1. Providers must meet ATR II provider eligibility requirements, based on the type of service(s) they provide.
2. Providers must report any changes in the conditions of ownership or leadership within their agency.
3. Providers must provide ABH with an accurate and current listing of all key and direct service staff.
4. Provide must train all staff to perform job duties including volunteers.
5. Providers must screen all potential recipients for eligibility for ATR II services.
6. Only authorized providers shall be permitted to conduct ATR II assessments allowing for accurate assessment of the level of care necessary for each recipient.
7. Providers must request vouchers for each recipient, based on the ATR II assessment outcome and only request vouchers that are deemed appropriate by the assessment.
8. Providers must be familiar with ATR II service definitions, to make appropriate voucher requests.
9. Providers must deliver services in a professional and ethical manner.
10. Providers must maintain documentation in recipient records to accurately reflect and support all services rendered under ATR II funding.
11. Providers must accurately track and report all service encounters.
12. Providers shall have the primary responsibility of ensuring that ATR II funds do not replace any existing funding already in place within the agency.
13. Providers shall have the primary responsibility of ensuring that ATR II service encounters are not billed to other funding resources and ATR II simultaneously.

ABH responsibilities include, but are not limited to, the following:

1. ABH shall only authorize and pay providers who have an executed the ATR II Provider Agreement and Rate Agreement detailing the services which they have been deemed eligible to provide.
2. ABH will maintain a toll-free hotline to allow consumers a means to report unprofessional or fraudulent behavior and to express concerns or receive information on ATR II services.
3. ABH must review recipient applications for eligibility as well as for completeness of documentation.
4. ABH must also document that recipients understand their rights and responsibilities as explained in the Consent to Participate form from each provider.
5. ABH must review all submitted service encounters for billing accuracy and reconcile them against all active vouchers issued to a recipient. Any discrepancies or concerns in the reporting of billable service encounters must be conveyed to, and resolved with, the reporting agency.
6. ABH will pay providers in a timely manner upon the submission of a clean claim.
7. ABH and DMHAS must conduct on-site audits for reasons to include, but not limited to: verifying that services are being delivered in a safe and professional manner, examining recipient records for documentation of all services, and comparing services billed against those documented as rendered.
8. ABH shall generate reports to monitor the following: referral patterns of providers, provider invoicing for services reported and rendered, the number of consumers served, the type of services being provided, and the amount paid for those services.

Recipient responsibilities include, but are not limited to, the following:

1. Recipients shall use the ATR II hotline number to report behavior that constitutes a violation of their rights or to report other circumstances of fraud, waste and abuse.
2. Recipients must justify any request to change provider.
3. Recipients must use vouchers in a responsible manner for the intended service or goods.

APPENDIX 1

CODE OF ETHICS FOR PREVENTION/RECOVERY PROFESSIONALS

Adapted from the code of the Connecticut Department of Mental Health and Addiction Services

PREAMBLE

The Principles of Ethics are a model of standards of exemplary professional conduct. This Code of Ethical Conduct expresses the professional's recognition of his responsibilities to the public, to service recipients, and to colleagues. They should guide providers serving DMHAS programs in the performance of their professional responsibilities. The Principles call for commitment to honorable behavior, even at the sacrifice of personal advantage. These principles should not be regarded as limitations or restrictions, but as goals toward which Recovery Professionals should constantly strive. They are guided by core values and competencies that have emerged with the development of the field.

PRINCIPLES

I. Non-Discrimination

A Recovery Professional shall not discriminate against service recipients or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition, or physical, medical or mental disability. A Recovery Professional should broaden his understanding and acceptance of cultural and individual differences, and in so doing, render services and provide information sensitive to those differences.

II. Competence

A Recovery Professional shall observe the profession's technical and ethical standards, strive continually to improve personal competence and quality of service delivery, and discharge professional responsibility to the best of his ability. Competence is derived from a synthesis of education and experience. It begins with the mastery of a body of knowledge and skill competencies. The maintenance of competence requires a commitment to learning and professional improvement that must continue throughout the professional's life.

- a. Professionals should be diligent in discharging responsibilities: to render services carefully and promptly, to be thorough, and to observe applicable technical and ethical standards.
- b. Due care requires a professional to plan and supervise adequately and evaluate to the extent possible any professional activity for which he is responsible.
- c. A Recovery Professional should recognize limitations and boundaries of competencies and not use techniques or offer services outside of his competencies. Each professional is responsible for assessing the adequacy of his own competence for the responsibility to be assumed.
- d. Ideally Recovery Professionals should be supervised by Nationally Registered Prevention Professionals (NRPP). When this is not available, Recovery Professionals should seek peer supervision or mentoring from other competent Recovery Professionals.
- e. When a Recovery Professional has knowledge of unethical conduct or practice on the part of an agency or Recovery Professional, he has an ethical responsibility to report the conduct or practices to appropriate funding or regulatory bodies or to the public.
- f. A Recovery Professional should recognize the effect of impairment on professional performance and should be willing to seek appropriate treatment for him or herself.
- g. Individuals and organizations providing recovery support services are obliged to stay current with best practices in substance abuse recovery, recovery management, and community resources.

III. Integrity

To maintain and broaden public confidence, Recovery Professionals should perform all responsibilities with the highest sense of integrity. Personal gain and advantage should not subordinate service and the public trust. Integrity can accommodate the inadvertent error and the honest difference of opinion. It cannot accommodate deceit or subordination of principle.

- a. All information should be presented fairly and accurately. Each professional should document and assign credit to all contributing sources used in published material or public statements.
- b. Recovery Professionals should not misrepresent either directly or by implication professional qualifications or affiliations.
- c. Where impairment is evident in a colleague or a service recipient, a Recovery Professional should be supportive of assistance or treatment.
- d. A Recovery Professional should not be associated directly or indirectly with any service, products, individuals, and organization in a way that is misleading.

IV. Nature of Services

Do no harm to service recipients. Services provided by Recovery Professionals shall be respectful and non-exploitative.

- a. Services should be provided in a way which preserves the protective factors inherent in each culture and individual.
- b. Recovery Professionals should use formal and informal structures to receive and incorporate input from recipients in the development, implementation, and evaluation of Recovery services.
- c. Where there is suspicion of abuse of children or vulnerable adults, the Recovery Professional shall report the evidence to the appropriate agency and follow up to ensure that appropriate action has been taken.
- d. The provider shall not impose, nor allow his/her staff or volunteer to, impose his/her own religious views or practices on recipients whose faith preference is different from his/her own.

V. Confidentiality

Confidential information acquired during service delivery shall be safeguarded from disclosure, including—but not limited to—verbal disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases. Recovery Professionals are responsible for knowing the confidentiality regulations relevant to their Recovery specialty.

VI. Ethical Obligations for Community and Society

According to their consciences, Recovery Professionals should be proactive on public policy and legislative issues. The public welfare and the individual's right to services and personal wellness should guide the efforts of Recovery Professionals to educate the general public and policy makers. Recovery Professionals should adopt a personal and professional stance that promotes health.

APPENDIX 2

SUMMARY: PRIVACY RULE OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Published as 45 CFR parts 160 and 164 and effective in 2003, this Act protects the privacy of Protected Health Information (PHI) that is:

1. Transmitted by electronic media;
2. Maintained in any medium described in the definition of electronic media; or
3. Transmitted or maintained in any other form or medium.

As defined by HIPAA, *Protected Health Information* is any information, including demographic information, collected from an individual, that is:

1. Created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse;
2. Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and which is
3. Able to identify the individual, or with respect to which, there is reasonable basis to believe that the information can be used to identify the individual.

Business associate as defined by HIPAA (45 CFR section 160.103), is a person who, on behalf of the covered entity or provider or of an organized healthcare arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

1. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing; or
2. Any other function or activity regulated by this subchapter; or provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized healthcare arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

All providers who qualify as *covered entities* must comply with the provisions of the Privacy Rule of HIPAA. A *covered entity* is defined as a healthcare provider, a health plan, or a clearinghouse who transmits any health information in electronic form in connection with a transaction covered by this subchapter (section 160.103 of 45 CFR part 160). If this provider is a covered entity, then HIPAA requires the appropriate policies and procedures to be in place to comply with the HIPAA Privacy Rule. HIPAA requires such policies and procedures to include, but not be limited to, the following topics: Notice of Privacy Practices, Amendment of Protected Health Information (PHI), Recipient Access to PHI, Accounting of Disclosures, Workforce Training, Verification, Authorization for Disclosures of PHI, HIPAA Complaint Process, Marketing (if applicable), Research (if applicable), Audit and Monitoring of HIPAA compliance, and Business Associates Agreements with those companies providing goods and services which require the disclosure of PHI, etc.

Where existing confidentiality protections provided by 42 CFR part 2, related to the release of alcohol and drug abuse records, are greater than HIPAA, then the department anticipates that the provider will consider any such provision of 42 CFR part 2 as the guiding language.

APPENDIX 3

PROVIDER TRAINING

VOUCHER MANAGEMENT SYSTEM AND GPRA TRAININGS

DMHAS and Advanced Behavioral Health endeavor to provide periodic trainings on (1) the GPRA assessment tool, (2) the web-based voucher management system, tracking and follow-up, as well as (3) other issues which may require technical assistance. Training announcements can be found on the ATR II Resources page at www.abhct.com.

CLINICAL PASTORAL TRAINING

For many recipients, spirituality is a key factor in recovery. As such, the recipient's spiritual well-being is as important as his or her physical and mental health. Within the recovery support service arena, a distinction is made between religion and spirituality to protect the religious preference of recipients.

Clinical Pastoral Training is provided by Marcus M. McKinney, D.Min. from St. Francis Hospital. "Each program reflects the spiritual dimension of healing found in everyday ministry. Classes are open to anyone whose work or ministry would benefit from pastoral counseling skills. Lay people and clergy of all faith orientations are encouraged to attend." Certificates are awarded upon completion of classes. Find more information and register for the classes at <http://www.stfranciscare.org/body.cfm?id=983>

DMHAS TRAINING

The DMHAS Education & Training Division promotes the highest standards of care by offering professional development of direct care, administrative, and managerial staff. A variety of training programs, workshops, and conferences are available to staff at DMHAS-funded agencies; a subset of these trainings can be accessed by any interested party. All trainings require pre-registration. For a list of trainings, see: <http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334766>

CCAR TRAINING

The Connecticut Community for Addiction Recovery (CCAR) training initiative provides comprehensive training and technical assistance to help people sustain their recovery, improve their quality of life, and become better resources for the community at large. This training is offered to the recovery community: persons in recovery, family members, friends, and allies. Please visit the following website to get a list of trainings: http://www.ccar.us/train_event.htm