

### New York State Independent Peer Review Treatment Program Protocol

Date of the Review (M/D/YYYY) 1/1/2004

Program Reviewed	Reviewer(s)
<i>Name of Program Being Reviewed</i> Click here and type the name of the program reviewed.	<i>Name of Program Conducting the Review</i> Click here and type the name of the program conducting the review.
<i>Address</i> Click here and type the address of the program reviewed.	<i>Address</i> Click here and type the address of the program conducting the review.
<i>Phone Number</i> Click here and type the phone number of the program reviewed.  <i>Fax Number</i> Click here and type the fax number of the program reviewed.	<i>Phone Number</i> Click here and type the phone number of the program conducting the review.  <i>Fax Number</i> Click here and type the fax number of the program conducting the review.
<i>Name(s), Title(s), Credential(s), and E-mail address(es) of Participating Staff of Program being Reviewed</i> Click here and type the names, titles, credentials, and E-mail addresses of staff participating in the review.	<i>Name(s), Title(s), Credential(s) and E-mail address(es) of Reviewer(s)</i> Click here and type the names, titles, credentials, and E-mail addresses of the Reviewers.
<i>Modality/Environment of Program Reviewed</i> Click here and type modality of the program reviewed.	<i>Modality/Environment of Program</i> Click here and type the modality of the program conducting the review.

## I. REVIEW SCOPE

Check the boxes indicating which sections were completed. As noted, the Clinical Section is required to meet Federal Regulations.

- I. Review Scope       II. Clinical (Required)       III. Quality Improvement Practices
- IV. Client Satisfaction       V. Research       VI. Additional Focus Areas
- VII. IPR Assessment       VIII. Summary

## II. CLINICAL REVIEW

*This section is mandatory in order to meet Federal SAPT Regulations*

**OBJECTIVE 1:** *To determine if the intake process respects the dignity of the client.*

1. Review Methodology
  - a.  Interviewed intake personnel
  - b.  Reviewed documentation of the process
  - c.  Observed the general admission area
  - d.  Interviewed client(s)
2. Focus Issues
  - a. How does the staff present themselves to clients?  

Click here and describe how staff presents themselves to clients.

Are they warm, informative, and non-threatening?  Yes  No

b. How is the client made to feel comfortable?

[Click here and describe how the client is made to feel comfortable.](#)

– What contributes most to clients feeling comfortable?

(Please rate: 1-contributes the least to 5- contributes the most – please assign each number only once).

\_\_\_ Environment    \_\_\_ Clinical Staff    \_\_\_ Office/Reception Staff    \_\_\_ Confidentiality  
\_\_\_ Other (please indicate)

[Click here and type comments](#)

Exceptional    Above Average    Average    Below Average  
           

c. Please rate the timeliness of admission

– What is the approximate length of time between initial contact and admission appointment?

24 hours     1-5 days     1 week     2 weeks     3 weeks     More than 3 weeks

If time between initial contact and admission appointment exceeds 1 week, please explain why.

[Click here and type comments](#)

d. How is the client informed of his/her rights?

[Click here and describe how the client is informed of his/her rights.](#)

e. Overall, how well does the intake process respect the dignity of the client?

Exceptional    Above Average    Average    Below Average  
           

[Click here and describe how the intake process respects the dignity of the client.](#)

f. Are there any opportunities for improvement in the program’s intake process not already identified?

Yes     No

[Click here and describe opportunities for improvement.](#)

g. Additional comments

[Click here and type comments](#)

**OBJECTIVE 2: To determine if the assessment process identifies the need for care, the appropriate level and setting for care, and forms the basis for a treatment plan.**

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1. Review Methodology

- a.  Reviewed charts (minimum 1 open and 1 closed file) Number reviewed    \_\_\_ Open    \_\_\_ Closed
- b.  Interviewed clinicians/intake personnel    d.  Observed the general admission area
- c.  Reviewed documentation of the process    e.  Interviewed clients

2. Focus Issues

a. Please rate how well the assessment indicates that the admission was appropriate to the admission criteria.

Exceptional    Above Average    Average    Below Average  
           

[Click here and type comments](#)

b. Please rate the program’s capacity to do effective screening for co-occurring disorders (Mental Health).

          

[Click here and type comments](#)

c. Is the level of care assessment appropriate?

Yes     No

[If no, click here and indicate how this could be improved.](#)

- d. (Methadone Programs) When applicable, based on the assessment, please rate any appropriate plans to meet the needs of clients with alcohol or other drug problems, in addition to the opiate dependence.
- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
|  | <i>Exceptional</i>       | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- [Click here and type comments](#)  Not Applicable
- e. Does the assessment support the diagnostic impression?  
[If no, click here and indicate how this could be improved.](#)  Yes  No
- f. Does the assessment identify and address areas of dysfunctionality?  
[If no, click here and indicate how this could be improved.](#)  Yes  No
- g. Please rate how well the assessment process:
- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
|   | <i>Exceptional</i>       | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
| Identifies the need for care                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Identifies appropriate level and setting for care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Forms the basis for a treatment plan              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- [Click here and type comments](#)
- h. Are there any opportunities for improvement in the program's assessment process not already identified?  Yes  No  
[Click here and describe opportunities for improvement](#)
- i. Additional comments  
[Click here and type comments](#)

**OBJECTIVE 3: To determine if the treatment plan provides a flexible guide for helping the client get better.**

1. Review Methodology
- a.  Reviewed charts      b.  Interviewed clinicians
2. Focus Issues
- a. How well does the treatment plan address problems noted in the psychosocial assessment and continuing care progress notes?
- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
|  | <i>Exceptional</i>       | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- [Click here and type comments](#)
- b. How well do treatment plan revisions accurately reflect client progress in addressing identified problems?  
[Click here and type comments](#)
- c. How well does the treatment plan provide a flexible guide for helping the client get better?  
[Click here and type comments](#)
- d. Are treatment goals achievable, based on the client's abilities and program's resources?  Yes  No  
[If no, click here and indicate how this could be improved.](#)
- e. How does the client participate in the planning process?  
[Click here and describe how the client participates in planning \(e.g. discussion during session, assignment, signing plan\).](#)  
 Client does not participate in development of plan.  
[If client does not participate, please indicate why.](#)
- f. What aspects of the treatment plan are noteworthy?  
[Click here and type noteworthy aspects of treatment plan.](#)

- g. Are there any opportunities for improvement in the program's treatment planning process not already identified?  Yes  No

[Click here and type opportunities for improvement.](#)

- h. Additional comments

[Click here and type comments](#)

**OBJECTIVE 4: To determine if the documentation demonstrates the delivery of appropriate treatment services to meet the client's needs in a timely manner.**

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1. Review Methodology

- a.  Reviewed charts
- b.  Interviewed clinicians

2. Focus Issues

	<i>Exceptional</i>	<i>Above Average</i>	<i>Average</i>	<i>Below Average</i>
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- a. Please rate how well progress notes tie into the treatment plan.

[Click here and describe how progress notes tie into treatment plan.](#)

- b. What aspects of the documentation process are noteworthy?

[Click here and describe which aspects of the documentation process are noteworthy.](#)

- c. Does the chart document the level of client functioning in response to treatment and justify the level of services?  Yes  No

[If no, click here and indicate how this could be improved.](#)

- d. Does documentation demonstrate the delivery of appropriate treatment services to meet the client's needs in a timely manner?  Yes  No

[If no, click here and indicate how this could be improved.](#)

- e. Is treatment provided and documented on a timely basis?  Yes  No

[If no, click here and indicate how this could be improved.](#)

- f. *(Methadone Programs)* Do clients with positive toxicology reports have their doses reviewed and, if necessary, adjusted?  Yes  No

[If no, click here and indicate how this could be improved.](#)  Not Applicable

- g. Are there any opportunities for improvement in the program's discharge plan not already identified?  Yes  No

[Click here and describe opportunities for improvement.](#)

- h. Additional comments

[Click here and type comments](#)

**OBJECTIVE 5: To determine if the discharge plan supports the client's recovery.**

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1. Review Methodology

- a.  Reviewed charts
- b.  Interviewed clinicians

2. Focus Issues

- a. What aspects of the discharge plan are noteworthy?

[Click here and describe which aspects of the discharge plan are noteworthy.](#)

	<i>Exceptional</i>	<i>Above Average</i>	<i>Average</i>	<i>Below Average</i>
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- b. Please rate how well the discharge plan supports client's recovery

[Click here and type comments](#)

- c. Is the discharge plan consistent with the documented history?  Yes  No

[If no, click here and indicate how this could be improved.](#)

- d. Is the continued care of the client addressed in the plan and does it meet the client's resources?  Yes  No  
[If no, click here and indicate how this could be improved.](#)
- e. Is the plan consistent with the client's level of functioning and resources?  Yes  No  
[If no, click here and indicate how this could be improved.](#)
- f. How does the client participate in the development of the plan?  
[Click here and describe how the client participates in planning \(e.g. discussion during session, assignment, signing plan\) and where it is documented.](#)  
 Client does not participate in the development of the plan.  
[Click here and type suggestions on how the client could participate.](#)
- g. Are there any opportunities for improvement in the program's discharge plan not already identified?  Yes  No  
[Click here and describe opportunities for improvement.](#)
- h. Additional comments  
[Click here and type comments](#)

OBJECTIVE 6: To determine the program's policies, procedures, and practices regarding treatment outcome.

1. Review Methodology
  - a.  Interviewed administrators, discharge coordinator, or evaluation/research staff, as appropriate.
  - b.  Reviewed documentation of process.
  - c.  Reviewed sample discharge summaries/aftercare plans.
2. Focus Issues
  - a. What, if any, documentation is collected by the program regarding treatment outcomes at discharge/post discharge and at what time intervals?  
[Click here and describe documentation collected.](#)  
 No documentation is collected.  
[Click here and type suggestions on how documentation could be collected.](#)
  - b. How is the information utilized for program improvement?  
[Click here and describe how information is utilized.](#)  
 Information is not utilized at this time.  
[Click here and type suggestions on how information could be utilized.](#)
  - c. Are there any opportunities for improvement in the program's policies, procedures, and practices regarding treatment outcomes not already identified?  Yes  No  
[Click here and describe opportunities for improvement](#)
  - d. Additional comments  
[Click here and type comments](#)

### III. QUALITY IMPROVEMENT PRACTICES

Programs Reviewed and Peer Reviewers participating in the 2003 Independent Peer Review may nominate a specific Program Practice to be recognized as a Quality Improvement Practice (QUIP). Selected program practices will be included in the 2003 Independent Peer Review Report and programs will be asked to present their practices at the next ASAP Conference.

Program practices, which can include clinical as well as non-clinical activities, will be considered based on the following:

- Practice Rationale: includes a review and assessment of the practice design, how the practice may be meeting a unique need of the community and/or population served and appropriateness of evaluation design(s).
- Practice Organization and Operation: includes a review of the practice, leadership, processes, and methods employed to achieve the desired results. It will look at how the practice goes beyond the minimum standards set in the chemical dependency regulations, and coordination with other services, as well as overall innovation.
- Measurements/Outcomes/Impact: assesses the quality and efficacy of the selected measures, the impact of the practice on the program, any statistical results for the practice to date, barriers to implementation, and the potential for replication. Practices must have been in operation a minimum of six months.

Examples of quality improvement practices include, but are not limited to the following:

Clinical Practices	Management	Motivational Enhancement Therapy (MET)	Dual Recovery Coordination
Prevention Activities	Administrative Functions	Performance Improvement in Organizations	Pharmacological Interventions
Workforce Improvement	Multi-Disciplinary Case Conference	Create an Environment of Continuous Learning for All Staff	Cognitive Behavioral Therapy (CBT)

If during your review, you or the program identify a program practice that should be considered as a QUIP, please answer the following questions and forward the answers to ASAP ***within seven days of the review***. Reviewers do not have to have completed the report prior to sending in this information.

Reviewer Information	
Name of Reviewer: Click here to enter Name of Reviewer.	Date of Review: 01/01/2004
Phone: Click here to enter Phone Number.	Fax: Click here to enter Fax Number.
E-mail: Click here to enter E-mail Address.	
Program Practice Information	
Name of Program Practice: Click here to enter Name of Program Practice.	
Contact Person: Click here to enter Contact's Name.	Title: Click here to enter Contact's Title.
Program Name: Click here to enter Program Name.	Modality: Click here to enter the Modality in which the Practice Operates.
Address: Click here to enter Address.	Phone: Click here to enter Phone Number.
City: Click here to enter City.	Fax: Click here to enter Fax Number.
State: New York	Zip: Click here to enter Zip Code.
E-mail: Click here to enter E-mail Address.	

**Practice Rationale**

1. Please briefly describe the identified program practice, why and how the program came about and the intended or actual outcomes.

[Click here to enter information](#)

Please rate the following areas of the identified practice:

- |  | <i>Exceptional</i>       | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. How well has the practice been designed to meet the identified need?<br><a href="#">Click here for additional comments</a>                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. How well has the program overcome barriers to implementation of this practice?<br><a href="#">Click here and briefly describe barriers.</a> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. How well does the practice meet the need of the community/program/population?<br><a href="#">Click here for additional comments</a>         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Practice Organization and Operation**

- |   | <i>Exceptional</i>       | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. How well has the initial practice design been operationalized?<br><a href="#">Click here for additional comments</a> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the practice appear to achieve the desired results?<br><a href="#">Click here for additional comments</a>       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | <i>Exceptional</i>       | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. Please rate how the practice goes beyond minimum standards.<br><a href="#">Click here for additional comments</a> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. How well is the practice integrated with other services?<br><a href="#">Click here for additional comments</a>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. How well is the practice being utilized?<br><a href="#">Click here for additional comments</a>                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. How well has the staff adapted to the new practice?<br><a href="#">Click here for additional comments</a>         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Measurements/Outcomes/Impact**

- |  | <i>Exceptional</i>       | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. How would you rate the quality of the identified practice?<br><a href="#">Click here for additional comments</a>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How would you rate the effectiveness of the identified practice?<br><a href="#">Click here for additional comments</a>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <i>Yes</i>               | <i>No</i>                | <i>Not Clear</i>         |                          |
| 3. Have there been any barriers to implementation?<br><a href="#">Click here and briefly describe barriers</a>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| 4. How would you rate the program practices overcoming barriers to implementation?<br><a href="#">Click here for additional comments</a>                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. How would you rate the potential for replication?<br><a href="#">Click here for additional comments</a>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the program implemented a mechanism to identify whether or not the practice has achieved desired results?<br><a href="#">Click here for additional comments</a> | <i>Yes</i>               | <i>No</i>                | <i>Not Clear</i>         |                          |
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |
|  |                          | <i>Above Average</i>     | <i>Average</i>           | <i>Below Average</i>     |
| 7. Based on your judgment, how effectively has this practice been operating?<br><a href="#">Click here for additional comments</a>                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## IV. CLIENT SATISFACTION REVIEW

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1. Review Methodology
  - a.  Interviewed clients
  - b.  Reviewed client satisfaction surveys or other means used to measure client satisfaction, if available.
2. Suggested Focus Issues
  - a. Please describe how the program assesses client satisfaction.
  - b. Please rate how the program assesses client satisfaction.
 

	<i>Exceptional</i>	<i>Above Average</i>	<i>Average</i>	<i>Below Average</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  - c. Please rate how well the clients feel that the program serves their needs.
  - d. Please rate client satisfaction with the services received
  - e. Please rate the degree to which the clients were treated in a sensitive and respectful manner
  - f. Do the clients feel welcome?  Yes  No
  - g. How is the client informed of the procedures to be used for filing complaints, both internally and externally to OASAS?  
  
 Client is not informed of the procedures.
  - h. Are there any opportunities for improvement in the program's addressing client satisfaction not already identified?
  - i. Additional comments

## V. RESEARCH

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1. Please rate the degree to which the program's current practices are based on research/science-based practice(s).
 

	<i>Exceptional</i>	<i>Above Average</i>	<i>Average</i>	<i>Below Average</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has or is the program currently involved in a research project?  Yes  No
  - a. If Yes – Please identify the research partners, source of funding, and the topic of the research.
  - b. If No – What current barriers exist in the program and/or the field that prevent involvement in research?

3. What mechanisms for information flow, in the area of treatment and research information, exist in the program?

[Click here and describe information flow mechanisms.](#)

4. Are there any opportunities for improvement in the program’s research area not already identified?

[Click here and describe opportunities for improvement.](#)

5. Additional comments

[Click here and type comments](#)

## VI. ADDITIONAL FOCUS AREAS

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*Use this section to report on any additional areas reviewed.*

[Click here and describe any additional focus areas reviewed.](#)

## VII. REVIEWER’S ASSESSMENT OF THE INDEPENDENT PEER REVIEW PROCESS

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Please comment on recommendations for improving the overall peer review process and the Peer Review Protocol, Guidelines and Report Format.

1. What part(s) of the Peer Review did you find most helpful/useful?

[Click here and describe the most helpful part\(s\).](#)

2. What part(s) of the Peer Review did you find least helpful/useful?

[Click here and describe the least helpful part\(s\).](#)

3. What additional areas would you include as part of the review?

[Click here and identify additional areas to include.](#)

4. What changes to the review instrument would you recommend?

[Click here and identify changes in the review instrument.](#)

5. Would you participate in the Independent Peer Review Process again?  Yes  No

[If no, please explain why you would not participate again.](#)

6. Additional comments

[Click here and type comments](#)

## VIII. REVIEW SUMMARY

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*This section summarizes the entire review using the questions below.*

	<i>Exceptional</i>	<i>Above Average</i>	<i>Average</i>	<i>Below Average</i>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- A. Please rate your overall impression of this program?

[Click here and type your overall impression of the program.](#)

- B. What approach(es) is the program using that appear(s) to enhance the clinical and/or administrative functioning of the program and which other programs might replicate?

[Click here and type program's approaches that enhance functioning.](#)

- C. From your review, in which sections/areas did you make suggestions as to what they might do to improve or address?

Clinical:  Intake Process  Assessment Process  Treatment Plan  Documentation  
 Discharge Plan  Treatment Outcome  Client Satisfaction  Research

[Click here and type recommendations if not included in the identified sections.](#)

D. What have you learned in the process of doing this review that will be beneficial to your own program?

[Click here and type what you have learned that would be beneficial to your program.](#)

E. Additional comments

[Click here and type comments](#)