

**PROVIDER CERTIFICATION MANUAL  
FOR  
COMMUNITY SUPPORT SERVICES PROGRAMS**

**Assertive Community Treatment  
(ACT)**

**DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE**

## OVERVIEW

This manual contains the standards by which the Division of Substance Abuse and Mental Health (DSAMH) certifies Assertive Community Treatment (ACT) for persons with psychiatric disabilities. Certification is required for provider enrollment with the Division of Social Services, Delaware Division of Medicaid and Medical Assistance (DMMA) Program for Medicaid reimbursement through the rehabilitative services option of Title XIX of the Social Security Amendments.

Through an Inter-Divisional Agreement the Division of Substance Abuse and Mental Health has been delegated authority for administration of certain provisions of the Medicaid program pertaining to behavioral health services covered under the rehabilitative services option. These provisions include the following: 1) certification of programs for provider enrollment, 2) rate setting, and 3) performance improvement. Delegated performance improvement functions include program monitoring, utilization control, training and technical assistance.

The Delaware Medicaid and Medical Assistance Program requires providers of behavioral health rehabilitative services to be certified by DSAMH as a condition of enrollment before they may provide services to eligible Medicaid recipients. Behavioral Health rehabilitative services are medically related treatment, rehabilitative and support services for persons with disabilities caused by mental illness, and substance use disorders. The Assertive Community Treatment (ACT), Psychosocial Rehabilitation Center (PRC) and Residential Rehabilitation Facility (RRF) are categories of community support programs that the Division certifies as one of the criteria for Medicaid provider enrollment. Services are provided for as long as is medically necessary to assist service recipients to manage the symptoms of their illnesses, minimize the effects of their disabilities on their capacity for independent living and prevent or eliminate periods of inpatient treatment.

## 1 CERTIFICATION FOR PROVIDER PARTICIPATION

1.1 *Authority*– Through an Inter–Divisional Agreement, the Division of Health and Social Services (DHSS) Delaware Medical Assistance Program (DMAP) has delegated the function of certifying organizations for enrollment as providers of optional behavioral health community support services to the Division of Substance Abuse and Mental Health (Division or DSAMH).

1.2 *Certification Criteria*– Eligibility for certification to provide community support services is determined according to the following criteria:

1.2.1 Organizations eligible to apply for provider certification and enrollment with DHSS for Medicaid reimbursement of Community Support Services include:

1.2.1.1 Private non–profit human service corporations;

1.2.1.2 Private for–profit human service corporations;

1.2.2 The Division bases its certification of programs and enrollment recommendations to DHSS upon the organization's compliance with state–level organizational, administrative and program standards that are consistent with federal Medicaid requirements related to Rehabilitative Services.

1.2.3 The Division establishes and applies minimum compliance guidelines to be used in making certification determinations.

1.2.4 The Division uses a certification survey to measure compliance with organizational, administrative and program standards. The determination with regard to a program's certification is based on:

1.2.4.1 Statements made and certified by authorized representatives of the organization;

1.2.4.2 Documents provided to the Division by the organization;

1.2.4.3 Documented compliance with organizational, program and administrative standards;

1.2.4.4 On–site observations by surveyor.

## 2 Definitions

***ACT (Assertive Community Treatment) Team*** is a group of ten (10) ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ACT team members are assigned by the team leader and the psychiatric prescriber to work collaboratively with an individual and his/her family and/or natural supports in the community by the time of the first individual assessment and subsequent person directed recovery planning meeting. The ACT team serves up to 100 individuals and thus has a maximum staff to client ratio of 1:10.

The core members of the team are the primary care manager, the psychiatric prescriber, at least one nurse, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each individual. The team has continuous responsibility to be knowledgeable about the individual's life, circumstances, goals and desires; to collaborate with the individual to develop and write the recovery plan; to offer options and choices in the recovery plan; to ensure that immediate changes are made as a individual's needs change; and to advocate for the individual's wishes, rights, and preferences. The ACT team is responsible for providing much of the individual's treatment, rehabilitation, and support services. Team members are assigned to take separate service roles with the individual as specified by the individual and the person directed recovery plan.

***Assistance with medications (AWSAM)*** means a situation where a designated care provider who has taken a Board approved medication training program, or a designated care provider who is otherwise exempt from the requirement of having to take the Board approved self administration of medication training program, assists the patient in self-administration of medication other than by injection, provided that the medication is in the original container with a proper label and directions. In cases where medication planners are used, the individual to whom the medication is prescribed must fill the planner. The designated care provider may hold the container or planner for the patient, assist with the opening of the container, and assist the patient in taking the medication.

AWSAM is conducted with the individual present. When delivering medications to the individual in the community, medications must be in their original containers or a labeled container with the name of the medication, dosage, dosing directions and name of the psychiatric prescriber prescribing the medication. (*Delaware Nurse Practice Act*, Title 24 Del. Code Ch. 19, 1902)

***Adverse Events*** are confirmed incidents of abuse, neglect, mistreatment, financial exploitation, and/or significant injuries which require reporting and investigative processes in accordance to DSAMH policies.

***Atypical Antipsychotic Medications*** (also known as “second generation medications”) are those medications used in the treatment of individuals diagnosed with schizophrenia and bipolar conditions.

***BioPsychoSocial (BPS)*** is an assessment positing that biological, psychological, and social factors are together related as significant factors in human functioning in the context of disease or illness.

***Clinical Supervision*** is a systematic process to review each individual's clinical status and to ensure that the individualized services and interventions that the team members provide (including the peer specialist) are planned with, purposeful for, effective, and satisfactory to the individual. The team leader and the psychiatric prescriber have the responsibility for providing clinical supervision that occurs during daily organizational staff meetings, recovery planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, recovery plans, progress notes, correspondence) in conjunction with each recovery plan review and update, upon an individual re-entering ACT or ICM services after a hospitalization of 30 days or more or any time there has been a change to the course of service provision as outlined in the most current recovery plan.

***Comprehensive Assessment*** is the organized process of gathering and analyzing current and past information with each individual and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and, 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity, personal/professional roles, talents, personal traits) that can act as resources to the individual and his/her recovery planning team in pursuing goals. The results of the information gathering and analysis are used to: 1) establish immediate and longer-term service needs with each individual; 2) set goals and develop the first person directed recovery plan with each individual; and, 3) optimize benefits that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

***Co-Occurring Disorders (COD) Services*** include integrated assessment and treatment for individuals who have co-occurring mental health and substance use condition.

***Crisis Assessment and Intervention*** includes services offered twenty-four (24) hours per day, seven days per week for individuals when they are experiencing an event that requires immediate response from a team member or other mental health professional. This includes a presence at local emergency departments and state crisis response settings (e.g. CAPES, CAPAC).

***Daily Log*** is a written document maintained by the ACT team on a daily basis to provide: 1) a current roster of individuals served by the team; and, 2) for each individual, a brief description of any treatment or service contacts which have occurred during the day and a concise behavioral description of the individual's clinical status and any additional needs.

***Daily Organizational Staff Meeting*** is a daily ACT team meeting held at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program individuals; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise recovery plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

***Daily Staff Assignment Schedule*** is a written, daily timetable summarizing all individual treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly individual schedules.

***DHSS*** refers to the Delaware Department of Health and Social Services.

***DMMA*** refers to the Delaware Division of Medicaid and Medical Assistance, providing health care coverage to individuals with low incomes and to those with disabilities, ensuring access to high quality, cost effective and appropriate medical care and supportive services.

***DSAMH*** refers to the Delaware Division of Substance Abuse and Mental Health within the Department of Health and Social Services.

***Family and Natural Supports' Psycho-education and Support*** is an approach to working in partnership with families and natural supports to provide current information about mental illness and to help them develop coping skills for handling problems posed by mental illness as experienced by a significant other in their lives.

***Health Homes*** were established within the Affordable Care Act to coordinate care for people with Medicaid who have chronic conditions, operating under a “whole-person” philosophy, integrating and coordinating all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

***Individual*** is an adult, age eighteen (18) and older who is receiving person-centered treatment, rehabilitation, and support services from the ACT or ICM team.

***Individual Therapy*** includes therapeutic interventions that help people make changes in their feelings, thoughts, and behavior in order to clarify goals and address stigma as they move toward recovery. Empirically-supported psychotherapy such as cognitive-behavioral therapy and supportive therapies also help individuals understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and evaluate the personal effectiveness and appropriateness of treatment and rehabilitative services available to them.

***Informed Consent*** means that the consumer has an understanding of the purposes, risks and benefits of each medication or treatment prescribed, as well as his/her rights to refuse medication or treatment.

***Initial Assessment and Person directed recovery plan*** is the initial evaluation of: 1) the individual's mental and functional status; 2) the effectiveness of past treatment; 3) the current treatment, rehabilitation and support service needs, and 4) the range of individual strengths that can act as resources to the person and his/her team in pursuing goals. The results of the information gathering and analysis are used to establish the initial recovery plan to achieve individual goals and support recovery. Completed the day of admission, the individual's initial assessment and recovery plan guides team services until the comprehensive assessment and full person directed recovery plan is completed.

***Illness/Symptom Management*** is an approach directed to help each individual identify and target the undesirable symptoms and disruptive manifestations of his or her mental illness and develop methods to help reduce recurrence and impact of those symptoms. Methods include identifying triggers and warning signs associated with specific symptoms, and learning ways to prevent and cope with symptoms.

***Instrumental Activities of Daily Living (IADL)*** include approaches to support individuals and build skills in a range of activities of daily living, including but not limited to finding housing, performing household activities, increased independence in carrying out personal hygiene and grooming tasks, money management, accessing and using transportation resources, and accessing services from a physician and dentist.

***Interdisciplinary Approach*** is the service model whereby team members from multiple disciplines analyze and synthesize shared roles and systematically collaborate and train each other in the methods associated with their expertise across assessment and service activities to reap the benefits of each member's unique point of view. The purpose of this approach is to share responsibility for services to consumers and to pool and integrate the expertise of team members so that consumers receive the specific evidence-based and client-centered services they need to achieve their goals. The communication expectation in this type of team involves continuous collaboration among all members (inclusive of the individual and, if desired, his/her family/other natural supports) on a regular, planned basis.

***Medication Administration*** is the physical act of giving medication to individuals in an ACT or ICM program by the prescribed route that is consistent with state law and the licenses of the professionals privileged to prescribe and/or administer medication (e.g., psychiatric prescribers, nurse practitioners, registered nurses, and pharmacists).

***Medication Adherence Education*** involves the sharing of information from the ACT team members to the individual or the individual's natural supports about pros and cons of taking medication for mental health conditions. Peers may *not* assist with medication adherence education.

***Medication Assistance*** is the oversight of medication adherence where a member of the ACT team observes or provides training in self-administration of medication. With the exception of a registered nurse or psychiatric prescriber, all team members must receive Assistance With Self Administered Medication (AWSAM) training at the beginning of employment and annually thereafter. Team members required to participate in AWSAM training

may not observe medication assistance prior to completing initial AWSAM training during orientation and annual training thereafter. *Peers may assist in medication assistance only when the team has determined that only the Peer will have the most success in helping the individual adhere to a prescribed medication regimen; this allowance must be time limited along with a plan to disengage the peer from providing this service in addition to pre-approval by DSAMH.*

**Medication Error** is any error in prescribing, administering or delivering a specific medication, including errors in writing or transcribing the prescription, in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

**Medication Management** is a collaborative effort between the individual and the psychiatric prescriber with the participation of the team to provide training in medication adherence and to carefully evaluate the individual's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other medication; to choose a medication treatment; and to establish a method to prescribe and evaluate medication response according to evidence-based practice standards.

**Nurse Licensure Compact** is a nurse who is licensed in one of the participating Compact (Multi-State) Licensure states. A compact license allows a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) to work in another state without having to obtain licensure in that state. The state where the nurse is licensed and the state where the nurse works **both** must be parties to the compact agreement.

**Peer Support and Wellness Recovery Services** are services provided by team members who have experience as recipients of mental health services. The role of the peer support includes providing services that serve to validate individuals' experiences, provide guidance and encouragement to individuals to take responsibility for and actively participate in their own recovery, and help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma. The DSAMH Scope of Practice for peers shall be the guide for utilizing this resource.

***Person-Directed Recovery plan (PDRP)*** is the product of a continuing process involving each individual, his/her family and/or natural supports in the community, and the ACT team, which tailors service activity and intensity to meet the individual's specific treatment, rehabilitation, and support needs. The written recovery plan documents the individual's strengths, resources, self-determined goals, and the services necessary to help the individual achieve them. The plan also delineates the roles and responsibilities of the team members who work collaboratively with each individual in carrying out the services.

***Primary care manager*** under the supervision of the Team Leader, the primary care manager leads and coordinates the activities of the individual treatment team (and is the team member who has primary responsibility for establishing and maintaining a therapeutic relationship with an individual on a continuing basis, whether the individual is in the hospital, in the community, or involved with other agencies. In addition, he or she is the responsible team member to be knowledgeable about the individual's life, circumstances, and goals and desires.

The primary care manager develops and collaborates with the individual to write the person directed recovery plan, offers options and choices in the recovery plan, ensures that immediate changes are made as the individual's needs change, and advocates for the individual's wishes, rights, and preferences. The primary care manager also works with other community resources, including individual-run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the individual. The primary care manager provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people. In most cases the primary practitioner is the first team member available to the individual in crisis. The primary care manager shares these service activities with other members of the team who are responsible to perform them when the primary care manager is not working.

***Program*** refers to the ACT services team that provides service in accordance with these standards.

***Psychiatric Prescriber means*** a physician or psychiatric nurse practitioner, licensed by the State of Delaware who has specific clinical experience in the treatment of mental health disorders. Psychiatric Prescribers must have specific training in pharmacology and in applicability of psychotropic medications used with individuals who have a mental health diagnosis and have full privileges to diagnosis mental health disorders and prescribe psychotropic medications by virtue of their professional license.

***Psychotropic Medication*** is any drug used to treat, manage, or control psychiatric symptoms or behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anti-anxiety agents.

***Recovery Plan Review*** is a thorough, written summary describing the individual's and the *interdisciplinary* team's evaluation of the individual's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person directed recovery plan. The Recovery Plan Review provides a basis for making needed refinements in the individual's service plan and includes active participation by the individual served.

***Recovery Planning Meeting*** is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of the meeting is for the staff, and the individual and his/her family/natural supports (all working as a team) to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment to learn as much as possible about the individual's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each individual and his/her goals and aspirations and for each individual to become familiar with each team member; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; and to fully understand the recovery plan rationale in order to carry out the plan for each goal.

***Service Coordination*** is a process of organization and coordination within the interdisciplinary ACT or ICM team to carry out the range of treatment, rehabilitation, and support services each individual expects to receive in accordance with his or her written person directed recovery plan and that are respectful of the individual's wishes. Service coordination also includes coordination with community resources, including individual self-help and advocacy organizations that promote recovery.

*Serious and Persistent Mental Illness (SPMI)* is an adult with a serious and persistent mental illness, "1" below must be met, in addition to either "2", "3", or "4":

1. Designated Mental Illness

The individual is 18 years of age or older and currently meets the criteria for a DSM-5 psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD-Coding Manual psychiatric categories and codes that do not have an equivalent in DSM-5 are also included mental illness diagnoses.

And

2. SSI or SSDI due to Mental Illness

The individual is currently enrolled in SSI/SSDI due to a designated mental illness.

Or

3. Extended Impairment in Functioning due to Mental Illness

a. Documentation that the individual has experienced two of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis:

- i. Marked difficulties in self-care (personal hygiene, diet, clothing, avoiding injuries, securing health care or complying with medical advice).
- ii. Marked restriction of activities of daily living (maintaining a residence, using transportation, day to day money management, accessing community services).
- iii. Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
- iv. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings, individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

Or

4. Reliance on Psychiatric Treatment, Rehabilitation and Supports

A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

***Social and Community Integration Skills Training*** provides support to individuals in managing social and interpersonal relationships and leisure time activities, with an emphasis on skills acquisition and generalization in integrated community-based settings.

***Supported Education*** provides the opportunities, resources, and supports to individuals with mental illness so that they may gain admission to and succeed in the pursuit of education including completing high school, (or obtaining a GED), post-secondary education and vocational school.

***Supported Employment*** is a service providing on-going individualized support to learn a new job or maintain a job in competitive or customized integrated work setting that meets job and career goals, including self employment, and are compensated at or above the minimum wage, in line with compensation to employees with the same or similar work by individuals without disabilities.

***Trauma-Informed*** organizations, programs, and services are based on an understanding of the vulnerabilities of triggers of trauma survivors that traditional services delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. Trauma-informed organizations take the steps necessary to make certain that, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.

***Vocational Services*** include work-related services to help individuals value, find, and maintain meaningful employment in community-based settings.

***Wellness Management and Recovery Services*** are a combination of psychosocial approaches to working in partnership with the individual to build and apply skills related to his or her recovery, including development of recovery strategies, building social support, reducing relapses, using medication effectively, coping with stress, coping with problems and symptoms, attending to physical needs and getting needs met within the mental health system, medical system and community.

### 3 Admission and Discharge Criteria

3.1 Admission Criteria Eligible recipients are certified by the psychiatric prescriber as being in medical need of program services in accordance with an assessment procedure approved by the Division for use in determining that individuals are diagnosed with mental health conditions according to criteria for severity of disability associated with mental illness.

3.1.1 The assessment must provide supporting evidence of the meeting criteria A, B, and C:

#### 3.1.1.1 Criterion A

3.1.1.1.1 The individual must meet all three (3) diagnostic criteria:

3.1.1.1.1.1 Serious and persistent mental illness (SPMI) that seriously impairs an individual's functioning in community living with a diagnosis on Axis I of 295.1,2,3,6,7,9 or 296.3,4,5,6,7 because these illnesses more often cause long-term psychiatric disability. Individuals must have a primary mental health diagnosis or co-occurring serious mental illness and substance use condition. Individuals with a sole diagnosis of a substance use disorder, mental retardation, brain injury or personality disorders are not the intended individuals for ACT services. Individuals with SMI may have a history of repeated hospitalizations and/or may be individuals who have not been able to remain abstinent from drugs or alcohol. Diagnoses that would otherwise be excluded from ACT services may be considered for an ACT team if an assessment by the team supports ACT services as the best course of service.

3.1.2.1.1.1 Significant impairments as demonstrated by at least two of the following conditions:

3.1.2.1.1.1.1 Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining or maintaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, relatives or the ACT team.

3.1.2.1.1.1.2 Interpersonal functioning

3.1.2.1.1.1.3 Concentration, persistence, and pace

3.1.2.1.1.1.4 Adaptation to change

3.1.3.1 Co-occurring substance use and SPMI or SMI of significant duration, e.g., greater than twelve (12) months.

3.1.2 Criterion B

3.1.2.1 The individual must be at least 18 years of age or older

3.1.3 Criterion C

3.1.3.1 The individual must meet at least one (1) of the following:

- 3.1.2.1.2 Psychiatric or Substance Abuse  
Hospitalizations/Juvenile Placement within the past twelve (12) months:
  - 3.1.2.1.2.1 Two or more psychiatric hospitalizations or substance abuse-related hospitalizations
  - 3.1.2.1.2.2 One psychiatric or substance abuse-related hospitalization in excess of 10 days
  - 3.1.2.1.2.3 Two or more juvenile placements in a secure facility
  - 3.1.2.1.2.4 One juvenile placement in a secure facility in excess of 90 days
- 3.1.2.1.3 Emergency Room Visits:
  - 3.1.2.1.3.1 Three or more psychiatric or substance abuse related emergency room visits in the past 12 months.
- 3.1.2.1.4 High risk or recent history of criminal justice involvement, e.g., arrest and incarceration.
  - 3.1.2.1.4.1 More than 1 arrest or frequent contacts with law enforcement (including active probation or parole)
  - 3.1.2.1.4.2 Ten or more days of incarceration
- 3.1.2.1.5 Individual is either currently in 1 of the following 4 housing risk categories OR has had 2 such episodes in the past 12 months:
  - 3.1.2.1.5.1: Street-dwelling homeless
  - 3.1.2.1.5.2 Living in homeless shelter
  - 3.1.2.1.5.3 Residing in substandard housing (no operable heat, electric, and/or plumbing or deemed uninhabitable)
  - 3.1.2.1.5.4 At imminent risk of becoming homeless due to an eviction notice or otherwise “kicked out” of someone else’s residence in a specified period of time

3.1.2.1.6 Hospitalizations:

3.1.2.1.6.1 Has resided in an in-patient setting in excess of 30 days in the past 12 months and is clinically assessed to be able to live in a more independent living situation

3.1.3 Documentation of admission shall include:

3.1.3.1 Evidence that one of the criteria in §3.1.1, §3.1.2, and §3.1.3 are met;

3.1.3.2 The reasons for admission as stated by both the individual and the team.

3.1.3.3 The signature of the psychiatric prescriber.

3.1.4 Engagement by the ACT team will begin within five (5) days of referral

3.1.5 Admission into the ACT team shall be completed within 30 days from date of referral;

3.1.5.1 Any exceptions to engagement or enrollment must be reported to the EEU; all documented engagement attempts shall be provided to DSAMH/EEU upon request.

3.1.6 DMMA and DSAMH shall require a full review of medical necessity in the event that a determination of medical necessity by the program physician does not appear to be supported by the assessment materials.

3.2 Requests for Discharge from services shall occur when an individual:

3.2.1 Has successfully reached individually-established goals (i.e. Demonstrates an ability to function in all major role areas such as work, social, self-care) for discharge and when the individual and program staff mutually agrees to the transition to less intensive services;

3.2.2 Moves outside the geographic area of ACT responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT program or another provider wherever the individual is moving. The ACT team shall maintain contact with the individual until this service transfer is complete;

- 3.2.3 Has received a score equal to or greater than 50, or a Mean Score equal to or greater than 2.8, from the Assertive Community Treatment Transition Readiness Scale which indicates, and when the individual and program staff mutually agrees to the transition from ACT to less intensive services;
- 3.2.4 Declines or refuses services and requests discharge, despite the team's documented best efforts to utilize appropriate engagement techniques to develop a mutually acceptable person directed recovery plan with the individual;
  - 3.2.4.1 Prior to discharge from ACT services, the EEU shall approve and/or request further information to review the circumstances, the clinical situation, the risk factors, and attempted strategies to engage the individual prior to the discharge of an individual from ACT services.
- 3.2.5 In addition to the discharge criteria listed above based on mutual agreement between the individual, ACT staff, an individual discharge may also be facilitated due to any one of the following circumstances:
  - 3.2.5.1 Death.
  - 3.2.5.2 Inability to locate the individual despite documented active outreach efforts by the team for a period of ninety (90) continuous days.
  - 3.2.5.3 Incarceration of ninety (90) days or more.
  - 3.2.5.4 Hospitalization or nursing facility care where it has been determined, based on mutual agreement by the hospital or nursing facility treatment team and the ACT team with approval of plan by EEU that the individual will not be appropriate for discharge from the hospital or nursing facility for a prolonged period of time
- 3.2.6 If the individual is accessible at the time of discharge, the team shall ensure individual participation in all discharge activities, or document all attempts to obtain signature.

3.2.7 The discharge summary shall include:

3.2.7.1 Date of discharge;

3.2.7.2 Reason for discharge;

3.2.7.3 Individual's status upon discharge based on the most recent assessment;

3.2.7.3.1 DSM diagnosis;

3.2.7.3.2 Summary of progress toward meeting goals as set forth in the individual's person directed recovery plan;

3.2.7.3.3 Documentation of the teams efforts to engage the individual in services, when relevant to the reason for discharge;

3.2.7.3.4 Aftercare/follow-up plan completed in conjunction with the individual;

3.2.7.3.5 The individual's contact information (i.e., forwarding address and/or phone number, email address).

3.2.7.4 The discharge summary shall be:

3.2.7.4.1 Completed within five (5) business days of discharge from the ACT team.

3.2.7.4.2 Signed and dated by:

3.2.7.4.2.1 The individual when the discharged is planned;

3.2.7.4.2.2 The primary care manager;

3.2.7.4.2.3 The physician;

3.2.7.4.2.4 The Team Leader.

3.2.8 The ACT Team shall develop and implement client discharge plans, including referral/transfer to appropriate post-discharge services.

## 4 Service Intensity and Capacity

### 4.1 Staff-to-Individual Ratio ACT:

4.1.1 Each ACT team shall have the organizational capacity to provide a staff-to-individual ratio of one (1) full-time equivalent (FTE) staff person for every ten (10) individuals served by the team

4.1.1.1 Distinct ACT teams are required.

4.1.2 The maximum number of individuals being served by any one ACT team is one hundred (100).

### 4.2 Staff Coverage

4.2.1 Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, crisis intervention and support services including twenty-four (24) hour/seven (7) days-a-week coverage.

### 4.3 Frequency of Individual Contact

4.3.1 The ACT team shall provide services based upon medical necessity. This system shall develop a frequency of face-to-face contact schedule that is in line with services that are medically necessary and is ideally mutually agreed upon between the consumer and the provider.

4.3.1.1 Frequency may be an average of three (3) face-to-face contacts per week at an average of one (1) hour per week.

4.3.2 The ACT team shall have the capacity to provide contacts per week that avail sufficient support with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as three to four times per day, seven days per week. All team members shall share responsibility for addressing the needs of all individuals requiring frequent contact as appropriate.

4.3.3 The following services as deemed necessary by assessment using assessment tools acceptable to DSAMH and prescribed by the individual recovery plan will be provided:

4.3.3.1 Psychiatric and substance abuse treatment;

4.3.3.1.1 Psychiatric prescriber: Face-to-face evaluation, minimally at fourteen (14) day intervals for the first sixty (60) days after admission, and then every thirty (30) days thereafter.

4.3.3.1.2 Chemical Dependency Specialist: Face-to-face evaluation minimally every fourteen (14) days for the first sixty (60) days after admission, and then as prescribed in the Individualized Treatment Plan that details on-going SUD evaluation schedule that is appropriate to the substance abuse.

4.3.3.2 Medication monitoring as follows:

4.3.3.2.1 The psychiatric prescriber will explain to the individual in language understandable to the consumer the various options for medication that can be used as part of treatment, their risks and benefits, common side effects, and the rationale for each medication proposed to be prescribed.

4.3.3.2.2 Informed consent shall be updated, at a minimum, annually.

4.3.3.2.3 Rationale for all changes in medication orders shall be documented in the physician's note.

4.3.3.2.4 All medication orders in the individual's case record shall specify:

4.3.3.2.4.1 Name of the medication (including brand and generic, if specified);

4.3.3.2.4.2 Dosage;

4.3.3.2.4.3 Route of administration;

4.3.3.2.4.4 Frequency of administration;

4.3.3.2.4.5 Signature of the physician prescribing the medication;

4.3.3.2.4.6 All known drug allergies.

4.3.3.2.5 Administration of medication by any method and/or the supervision of individuals in the self-administration of medication must be conducted and documented in conformance with the program's written policies and procedures for medication management.

4.3.3.2.5.1 Programs shall utilize a DSAMH approved Medication Administration Records (MAR) shall contain the following:

4.3.3.2.5.1.1 Name of all known (Somatic or Psychotropic) prescribed medications (including brand or generic, if specified);

4.3.3.2.5.1.2 Printed Name and Signature of Psychiatric Prescriber

4.3.3.2.5.1.3 Dosage;

4.3.3.2.5.1.4 Route of administration;

4.3.3.2.5.1.5 Frequency of administration;

4.3.3.2.5.1.6 All known drug allergies;

4.3.3.2.5.1.7 Name of the person administering or assisting with the administration of medication.

4.3.3.2.5.1.8 Signature of the person administering or assisting with the administration of medication.

4.3.3.2.5.2 Staff shall monitor and document individual adherence to following the prescribed medication treatment and the medication side effects to include the following:

4.3.3.2.5.2.1 Laboratory studies for all medications which require laboratory monitoring as recommended in the current Physician's Desk Reference;

4.3.3.2.5.2.1.1 Laboratory reports shall:

4.3.3.2.5.2.1.1.1 be reviewed and signed by the psychiatric prescriber within two (2) days of receipt.

4.3.3.2.5.2.2 Results of all laboratory studies shall be documented in the individual's chart within 30 days.

4.3.3.2.5.2.3 For persons receiving anti-psychotic medication:

4.3.3.2.5.2.3.1 , the AIMS (Abnormal Involuntary Movement Scale) shall be performed no less than annually to assess individuals at risk for developing Tardive Dyskinesia.

4.3.3.2.5.2.3.2 Annual screening for metabolic disorders in individuals prescribed atypical antipsychotic medications.

4.3.3.2.5.2.4 Education of individuals regarding side effects of prescribed

psychotropic medications and strategies for assuming responsibility for self-medication.

4.3.3.2.6 Monitoring of vital signs to include temperature, blood pressure, pulse, respiration, and weight at a minimum of once (1 time) per month.

4.3.3.2.6.1 BMI at a minimal frequency of every six (6) months, per American Psychiatric Association guidelines.

4.3.3.2.7 Metabolic assessment every (90) days for individuals taking atypical antipsychotic medications (including but limited to assessment for diabetes mellitus and hypertension.)

4.3.3.2.8 The program will use an evidence-based, trauma-informed assessment tool approved by DSAMH to assess the need for a trauma-informed treatment approach, and when appropriate, the need for trauma-specific interventions.

## 5 Staff Requirements

### 5.1 Qualifications

5.1.1 Each ACT team shall have among its staff persons with sufficient individual competence, professional qualifications and experience to provide:

- 5.1.1.1 service coordination;
- 5.1.1.2 medical nursing assessment;
- 5.1.1.3 trauma informed interventions;
- 5.1.1.4 crisis assessment and intervention;
- 5.1.1.5 recovery and symptom management;
- 5.1.1.6 individual counseling and psychotherapy;
- 5.1.1.7 medication prescription, administration, monitoring and documentation;
- 5.1.1.8 substance abuse counseling and co occurring counseling;
- 5.1.1.9 Supported housing assistance;
- 5.1.1.10 work-related and education-related services;
- 5.1.1.11 IADLs;
- 5.1.1.12 social, interpersonal relationship and leisure-time activity services;
- 5.1.1.13 support services or direct assistance to ensure that individuals obtain the basic necessities of daily life;
- 5.1.1.14 education, support, and consultation to individuals' families and other major supports; and
- 5.1.1.15 services that meet the requirements of the ADA/Olmstead and their implications for practice.

5.1.2 The staff should have sufficient representation of, and cultural competence in the local cultural population that the team serves.

## 6 ACT Team Size and Composition

6.1 The program shall employ ten (10) FTE interdisciplinary clinical staff persons, including one (1) FTE team leader and one (1) FTE peer specialist on the team.

### 6.2 Mental Health Professionals on Staff

6.2.1 Of the ten (10) FTE interdisciplinary clinical staff positions on an ACT team, there is a minimum of five (5) FTE mental health professionals (including one FTE team leader and excluding the psychiatric prescriber).

6.2.1.1 Mental health professionals are individuals with:

6.2.1.1.1 professional degrees (Masters level and above), licenses and/or certifications in one of the core mental health disciplines including but not limited to:

6.2.1.1.1.1 Psychiatric medicine;

6.2.1.1.1.2 Nursing;

6.2.1.1.1.3 Social work

6.2.1.1.1.4 Rehabilitation counseling;

6.2.1.1.1.5 Psychology;

6.2.1.1.1.6 Mental health counseling.

6.2.1.1.2 clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting;

6.2.1.1.3 clinical work experience with persons with SMI and/or SPMI and working toward certification or state issued licensure in a mental health discipline as defined in §6.2.1.1.1 of these standards.

6.2.2 Mental health professionals shall operate under the code of ethics and professional guidelines of their respective professions.

6.2.3 Required among the mental health professionals are:

6.2.3.1 Two (2) to three (3) FTE registered nurses (a team leader with a nursing degree may represent one (1) of these FTE nurses).

- 6.2.3.2 A minimum of two (2) FTE Master's level or above mental health professionals (including the team leader) and a minimum of two (2) FTE Bachelor's level mental health professionals.

## 7 ACT Required Staff

7.1 The chart below shows the required staff:

Position	Requirements
Team leader	1 FTE (Master's level)
Psychiatric prescriber	1 /FTE for 80–100 Individuals
Registered Nurse	2 FTE
Peer Specialist	1 FTE
Master's level	2 FTE
Bachelor's Level	3 FTE Including Housing Specialist (one can also be Registered Nurse)
Program/Administrative Assistant	1 FTE

OR

Position	Requirements
Team leader	1 FTE (Master's level)
Psychiatric prescriber	1 /FTE for 80–100 Individuals
Registered Nurse	3 FTE (A minimum of one RN must be at the Bachelor's level)
Peer Specialist	1 FTE
Master's level	2 FTE)
Bachelor's Level	2 FTE Including Housing Specialist
Program/Administrative Assistant	1 FTE

7.2 Chemical Dependency Specialists may be either the Master's level or Bachelor's level.

7.3 The following provides a description of and qualifications for required staff on an ACT team:

7.3.1 **Team Leader:** A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACT team. The team leader has at least a Master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatric prescriber. The team leader provides direct service to individuals at least six (6) hours per week.

7.3.2 **Psychiatric Prescriber** The psychiatric prescriber may include:

7.3.2.1 A person with a Medical Degree or Doctor of Osteopathy degree, licensed to practice medicine in Delaware and who has completed (or is enrolled in) an accredited residency training program in psychiatry, internal medicine or family practice.

7.3.2.2 A, licensed nurse practitioner who is license in the state of Delaware to diagnosis mental health disorders and prescribe psychotropic medications for such disorders and practices under the supervision of a psychiatrist.

7.3.2.3 The psychiatric prescriber works on a full-time basis in teams of one hundred (100) individuals on an ACT team. The psychiatric prescriber provides clinical support to all ACT individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

7.3.3 **Registered Nurses:** All registered nurses shall be licensed in the State of Delaware or participating in the Nurse Licensure Compact (NLC). A minimum of two (2) FTE and maximum of three (3) nurses are required. At least one (1) FTE nurse shall be at the bachelor's level or above.

7.3.4 **Master's Level Mental Health Professionals:** A minimum of two (2) FTE Master's level or above mental health professionals is required on each ACT team including the team leader.

7.3.5 ***Chemical Dependency Specialist:*** One (1) or more team members must be a Chemical Dependency Specialist with:

7.3.5.1 Certification by the State of Delaware as a Certified Alcohol and Drug Counselor (CADC) or Certified Co-occurring Disorder Professional (CCDP); or

7.3.5.2 at least three (3) years of supervised work experience in the substance abuse treatment field and;

7.3.5.2.1 Forty (40) hours of training specific to substance abuse assessment and treatment.

7.3.6 ***Peer Specialist:*** A minimum of one (1) FTE peer specialist is required on an ACT team. Because of his/her life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members, operating within their DSAMH approved scope of practice, who provide highly individualized services in the community and promote individual self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

7.3.7 ***Remaining Clinical Staff:*** The remaining clinical staff will include two (2) FTE Bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions, including one (1) FTE housing specialist with a minimum of one (1) year experience in interviewing housing applicants and determining if they're eligible for low-income housing, maintaining and updating tenant information, reviewing and analyzing financial information and computing housing assistant payments.

7.3.7.1 A Bachelor's level mental health worker has a Bachelor's degree in social work or a behavioral science, and work experience with adults with SMI and SPMI.

7.3.7.2 A paraprofessional mental health worker may have:

7.3.7.2.1 a Bachelor's degree in a field other than behavioral sciences; or

7.3.7.2.2 have a high school diploma and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. Paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

7.3.8 ***Vocational Specialist:*** Each team will make available one vocational specialist with training and experience in vocational services. The vocational specialist will be available for face-to-face meetings with the individual served.

**9 Policy and Procedure Requirements:**

9.1 The ACT program shall maintain a written Procedure Manual for its staff. A mechanism shall be in place to ensure that the procedures manual is updated periodically as needed but not less frequently than every (2) two years, and that the staff of the program is notified promptly of changes. The manual shall include:

9.1.1 A statement of the program's values and mission including the relationship of these factors to achieving the goals of the ADA and other essential rights of people with psychiatric disabilities, included shall be:

9.1.1.1 Policies and procedures that continually assess the program to assure:

9.1.1.2 A trauma informed and responsive environment;

9.1.1.3 An environment that is culturally sensitive to the populations that the programs services including ethnic/cultural/religious minorities and LGBTQ individuals;

9.1.2 Referral policies and procedures that facilitate individual referral;

9.1.3 Detailed procedures for assessment, recovery planning and documentation;

9.1.4 Policies and procedures for medication management in compliance with all applicable rules, regulations and requirements of the Delaware Board of Medical Practice, the Delaware Board of Nursing and the Delaware Board of Pharmacy (if applicable) to include policies and procedures for:

9.1.4.1 Prescribing medication;

9.1.4.2 Storage of medication;

9.1.4.3 Handling of medication;

9.1.4.4 Distribution of medication;

9.1.4.5 Disposing of medication;

9.1.4.6 Recording of medication used by individuals

9.1.4.7 Assistance with medication in accordance with AWSAMH.

- 9.1.5 Policies and procedures for handling on-call responsibilities and individual emergencies to include:
  - 9.1.5.1 specific program standards for intervention to avert hospitalization, criminal justice system involvement, or other harmful outcomes;
- 9.1.6 Policies and procedures for accessing and documenting the need for outside consultation to further the service goals or clinical needs of consumers;
- 9.1.7 Detailed instructions for application to and communication with entitlement authorities including but not limited to:
  - 9.1.7.1 The Social Security Administration;
  - 9.1.7.2 Social Services (SNAP, WIC, general relief, energy assistance, etc.)
    - 9.1.7.2.1 State Rental Assistance Program (SRAP), HUD/Section 8
  - 9.1.7.3 Medicaid;
  - 9.1.7.4 Medicare;
    - 9.1.7.4.1 Low Income Subsidy (LIS)
    - 9.1.7.4.2 Part D Medicare
  - 9.1.7.5 Prescription Assistance Program (PAP)
  - 9.1.7.6 Rep Payee (when applicable)
- 9.1.8 Policies and procedures for obtaining releases to share Protected Health Information about individuals with family members or others;
- 9.1.9 Policies and procedures regarding communicating and handling financial resources of the program;
- 9.1.10 Policies and procedures regarding the coordination of financial activities with the individual's representative payee for payment from the Social Security Administration;
- 9.1.11 Policies and procedures for the receipt, consideration and resolution of individual complaints and/or grievances regarding treatment decisions and practices or other program activities.

- 9.1.12 Policies and procedures for reporting instances of death, possible abuse or neglect, and adverse events to DHSS/DSAMH, law enforcement, and other entities in accordance with state and federal regulations and laws;
- 9.1.13 Policies and procedures for assisting consumers in securing legal counsel or other special professional expertise when needed;
- 9.1.14 Policies and procedures for ensuring that consumers are not subject to unwarranted coercion, including legal coercion (outpatient commitment, guardianship);
- 9.1.15 Policies and procedures to ensure that consumers are afforded an opportunity to execute Advance Directives or medical or legal documents to ensure that their preferences and considered in the event of a crisis or temporary inability to make informed decisions;
- 9.1.16 References to other policies, procedures, laws or regulations as may be promulgated or required by the federal government, the State of Delaware, the Department of Health and Social Services and its Divisions.

## 10 Personnel Management

10.1 The ACT program shall maintain an up-to-date Personnel Policies and Procedures Manual and make it readily available for reference by the program staff. The Manual will include:

10.1.1 Policies and procedures regarding equal employment opportunity and affirmative action to include compliance with:

10.1.1.1 The *Americans with Disabilities Act* including Olmstead (28 C.F.R. § 35.130) and the *Vocational Rehabilitation Act of 1973*, Sections 503 and 504 prohibiting discrimination against the handicapped; Title VII of the *Civil Rights Act of 1964* prohibiting discrimination in employment on the basis of race, color, creed, sex or national origin;

10.1.1.2 Title XIX of Del section 711 prohibiting discrimination on the basis of race, color, creed, sex, sexual orientation and national origin;

10.1.1.3 Age discrimination Act of 1975 prohibiting discrimination based on age;

10.1.1.4 Section 402 of the *Vietnam Era Veterans Readjustment Assistance Act* of 1974 prohibiting discrimination against disabled Vietnam Era veterans.

10.1.2 Policies and procedures for interviews and selection of candidates including:

10.1.2.1 Verification of credentials and references;

10.1.2.2 Criminal background checks including;

10.1.2.2.1 Registration on Adult Abuse and Child Abuse registries;

10.1.2.3 Policies and procedures for employee performance appraisal including;

10.1.2.4 A code of ethics;

10.1.2.5 Conditions and procedures for employee discipline including, termination of employment;

10.1.2.6 Conditions and procedures for employee grievances and appeals;

10.1.2.7 An annual staff development plan which shall include:

10.1.2.7.1 Provisions for orientation of paid staff, student interns and volunteers. Orientation shall include:

10.1.2.7.1.1 Review of these standards;

10.1.2.7.1.2 Review of the program's Procedures and Personnel manuals;

10.1.2.7.1.3 Assistance with Self Administration of Medication (AWSAM) in accordance with *Delaware Nurse Practice Act*, Title 24 Del. Code Ch. 19, 1902 and applicable rules and regulations.

10.1.2.7.1.4 Review of DHSS Policy Memorandum #46;

10.1.2.7.1.5 Review of section 5161 of Title 16 of the Delaware Code;

10.1.2.7.1.6 Review of the *Health Insurance Portability and Accountability Act* of 1996, 45 C.F.R. Parts 160 and 164;

10.1.2.7.1.7 Review of the Substance Abuse Confidentiality regulations codified at 42 C.F.R. Part 2.

10.1.2.7.1.8 Provisions for continuing education of staff;

10.1.2.7.1.9 Provisions for regularly scheduled clinical supervision which teach and enhance the clinical-skills of staff including:

10.1.2.7.1.9.1 Weekly team meetings led by the team leader during which assessments, recovery plans and progress toward treatment goals are reviewed and staff receives direction regarding clinical management of treatment issues.

- 10.1.2.7.1.10 Individual face-to-face sessions between the team leader and staff to review cases, assess performance and give feedback;
- 10.1.2.8 Maintenance and access to personnel files which shall contain employees' applications, credential (e.g. copy of a current license(s) and/or certification(s)), job descriptions, and performance appraisals, job titles, training, orientation, salary, staff statement of confidentiality.
- 10.1.2.9 Annual validation of credentials;
- 10.1.2.10 Notification by personnel to the program when made aware of any complaints filed against them with the licensing board or other credentialing organization; or upon conviction of any crime above a misdemeanor.
- 10.1.2.11 Work hours including hours of program operation, shifts and overtime compensation.
- 10.1.2.12 Agency policies regarding compensation including:
  - 10.1.2.12.1 Salary ranges, salary increases, and payroll procedures;
  - 10.1.2.12.2 Use of personal automobile for program activities;
  - 10.1.2.12.3 Reimbursement for work related expenses;
  - 10.1.2.12.4 Description of employee benefits.

## 11 Hours of Operation and Staff Coverage

11.1 The ACT team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities with 24 hours per day, seven days per week availability. This means:

11.1.1 Every team should have posted standard business hours of operation, to include:

11.1.2 Regularly operating and scheduling a minimum of one (1) ACT staff to work each weekend day and every holiday, to meet the individual needs of consumers' served.

11.1.3 Regularly scheduling ACT staff on-call duty to provide crisis services outside of regularly scheduled service provision operation which shall include responding in-person to a crisis or emergency situation.

11.1.4 Mental Health Professionals on the ACT staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call to provide back-up to on-call staff and be available to respond to individuals by phone or by in person visit to individuals who need face-to-face contact.

11.1.5 Regularly arranging for and providing psychiatric backup during all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the ACT psychiatric prescriber during all hours is not feasible, alternative psychiatric backup that meets the psychiatric prescriber criteria must be arranged

11.1.6 Through the use of the *Daily Organizational Staff Meeting* and the *Daily Staff Assignment Schedule* (ACT), adjusting schedules and providing staff to carry out the needed service activities in the evenings or on weekend days for individuals for whom this is necessary;

11.1.7 The ACT teams shall provide individuals served and, as applicable and with consent of the individual, and significant others with information about how to access staff in the event of an emergency including:

11.1.7.1 Rotating coverage 24/7, to be available for face-to-face contacts, and shall arrange with the crisis intervention service that the on-call team member should be notified when a face-to-face contact may be needed.

## 12 Place of Treatment

- 12.1 Seventy-Five (75%) percent of ACT service contacts shall be provided in non-office based or non-facility-based settings. The program will collect data regarding the percentage of individual contacts in the community as part of its Quality Improvement (QI) Plan and report this data during fidelity reviews.

## 13 Staff Communication and Planning

13.1 **The ACT team** shall conduct *daily organizational staff meetings* at regularly scheduled times per a schedule established by the team leader. These meetings may be conducted in accordance with the following procedures:

13.1.1 The ACT team shall maintain a written or computerized *daily log*. The daily log provides:

13.1.1.1 A roster of the individuals served in the program, and for each individual:

13.1.1.1.1 a brief description of any treatment or service contacts that have occurred during the last twenty-four (24) hours

13.1.1.1.2 a concise, behavioral description of the individual's status that day.

13.1.2 The *daily organizational staff meeting* shall commence with a review of the *daily log* to update staff on the treatment contacts that occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all individuals.

13.1.3 The ACT team, under the direction of the team leader, shall maintain a weekly individual contact schedule for each individual. The weekly individual contact schedule is a written schedule of all treatment and service contacts both face-to-face and by telephone that staff must carry out to fulfill the goals and objectives in the individual's person directed recovery plan.

13.1.3.1 The team will maintain a central file of all weekly individual schedules.

13.1.3.2 All weekly individual schedules shall be made available to DSAMH upon request.

13.1.4 The ACT team, under the direction of the team leader, shall develop a written or computerized *daily staff assignment schedule* from the central file of all weekly individual schedules. The daily staff assignment schedule is a written timetable for all the individual treatment and service contacts and all indirect individual work (e.g., medical record review, meeting with collaterals, in-patient hospital attendance, job development, recovery planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.

13.1.4.1 The daily staff assignment schedule shall be made available to DSAMH upon request.

13.1.5 The daily organizational staff meeting will include a review by the Team Leader of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the Team Leader will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, will prepare for in-patient treatment coordination, review previous treatment team attendance record, and the Team Leader will be responsible for assuring that all tasks are completed.

13.1.6 During the daily organizational staff meeting, the ACT team shall also work with the individual to revise person directed recovery plans as needed, anticipate emergency and crisis situations, and adjust service contacts on the daily staff assignment schedule per the revised recovery plans.

13.2 **The ACT team** shall conduct person directed recovery planning meetings under the supervision of the team leader and the psychiatric prescriber. These recovery planning meetings shall:

13.2.1 Convene at regularly scheduled times per a written or computerized schedule maintained by the team leader.

13.2.2 Occur and be scheduled when the individual and the majority of the team members can attend, including the psychiatric prescriber, team leader, and available members of the team. These meetings may also include the individual's family and/or natural supports, other professional supports, if

available and at the request of the individual and require individual staff members to be present and systematically review and integrate individual information into a holistic analysis and work with the individual and team to establish priorities for services.

13.2.3 Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each individual, his/her goals and aspirations and for each individual to become familiar with all team staff;

13.2.3.1 to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues;

13.2.3.2 to problem-solve treatment strategies and rehabilitation options;

13.2.3.3 to participate with the individual and the team in the development and the revision of the strengths based, person directed recovery plan;

13.2.3.4 to fully understand the recovery plan rationale in order to carry out the plan with each individual; and

13.2.3.4.1 updated, when significant clinical changes occur, and/or at the request of the individual, and/or significant change in mental status, and/or at the achievement of all goals found in the recovery plan, and at a minimum of every one-hundred-eighty (180) days.

13.2.3.4.2 Signed and dated by the individual, psychiatric prescriber, team leader, primary care manager(s), and other natural, peer, or professional supports when necessary.

13.2.3.5 to establish outcome oriented goals in order to achieve a recovery-based discharge from the program.

## 14 Staff Supervision

14.1 Each ACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader and psychiatric prescriber shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

14.1.1 Participation with team members in daily organizational staff meetings and regularly scheduled recovery planning meetings to provide staff direction regarding individual cases;

14.1.2 Monthly, formal supervisory meetings with individual staff members to review their work with individuals, assess clinical performance, and give feedback;

14.1.3 Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, recovery plans, recovery plan reviews); and

14.1.4 Written documentation of all clinical supervision provided to team staff shall be completed and maintained by the Team Leader.

14.1.4.1 Written documentation shall be signed and dated by the team leader at the time of the supervision session.

## 15 Evaluation & Assessment

- 15.1 **Initial Psychiatric Evaluation:** Admission to the program shall commence with the initial psychiatric evaluation completed by the psychiatric prescriber, followed by an initial crisis plan and initial recovery plan within twenty-four (24) hours of the individual's admission to ACT by the team leader or by designated team members.
- 15.2 **Comprehensive Assessment:** A complete bio-psycho-social (BPS) assessment shall be completed by a Mental Health Professional. A team member with training in specific areas on the BPS may complete the section of the BPS that is their area of expertise. A comprehensive assessment shall be initiated and completed in collaboration with the individual within thirty (30) days after a individual's admission according to the following requirements and findings presented at the first recovery planning meeting:
- 15.2.1 *Psychiatric History, Mental Status, and Diagnosis:* The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment (which includes the most up-to-date DSM V diagnosis).
  - 15.2.2 *Education and Employment:* Included in this area is the assessment of community inclusion and integration as it relates to education and employment.
    - 15.2.2.1 Vocational and educational functioning
  - 15.2.3 *Social Development and Functioning:* Included in this area is the assessment of the individual's social and interpersonal inclusion and integration within the community.
    - 15.2.3.1 Current social functioning;
    - 15.2.3.2 Legal history to include legal issues.
  - 15.2.4 *Instrumental Activities of Daily Living (IADL):* Included in this area is an assessment of the individual's abilities and barriers in meeting day to day activities for independence. This assessment includes but is not limited to:

- 15.2.4.1.1 Budgeting and money management
  - 15.2.4.1.1.1 Financial status, including eligibility/access to entitlements;
- 15.2.4.1.2 Shopping for groceries and other personal needs
- 15.2.4.1.3 Housekeeping
- 15.2.4.1.4 Conditions of Living
  - 15.2.4.1.4.1 Adequate housing with housing assessment made available to DSAMH upon request
- 15.2.4.1.5 Personal care (bathing, grooming etc...)
- 15.2.4.1.6 Laundry
- 15.2.4.1.7 Other activities required for independent living.

15.2.5 *Family Structure and Relationships:* Included in this area of the assessment is the extent to which family, friends and other supports are currently involved in the individual's care, and plans to include the family, friends and other supports in treatment moving forward, including:

15.2.6 *Strengths and Resources:* Members of the individual's ACT or ICM team are responsible for engaging the individual in his or her own recovery planning in order to identify individual strengths and resources as well as those within the individual's family, natural support network, service system, and community at large. These may include:

- 15.2.6.1 Personal skills, and talents;
- 15.2.6.2 personal virtues and traits;
- 15.2.6.3 interpersonal skills;
- 15.2.6.4 interpersonal and environmental resources;
- 15.2.6.5 cultural knowledge;
- 15.2.6.6 knowledge gained from struggling with adversity;
- 15.2.6.7 knowledge gained from occupational and parental roles;
- 15.2.6.8 spirituality and faith;
- 15.2.6.9 hopes, and dreams; and
- 15.2.6.10 goals, and aspirations.

15.2.7 While the assessment process shall involve the input of most, if not all, team members, the individual's psychiatric prescriber and/or team leader will assure completion of the written narrative.

15.2.8 The Comprehensive Assessment shall be signed, and dated by:

15.2.8.1 the primary care manager completing the evaluation;

15.2.8.2 the psychiatric prescriber; and

15.2.8.3 the team leader.

15.3 An up-dated, annual assessment shall be completed on each annual certification date for each individual. In addition to the assessment requirements in §15.0 of these standards, the annual assessment shall:

15.3.1 Assess the individuals readiness for transition with guidance provided by the approved DSAMH ACT Transition Readiness Assessment and the ACT team to less intensive services;

15.3.2 Review the progress achieved in accordance to the outcome-oriented recovery plan and reviewing what is required in order to continue in a recovery-based trajectory to a less intensive level of care;

15.3.3 Ensure a gradual, individualized process which ensures continuity of care and preservation of consumer preferences when transitioning to less intensive services;

## 16 Physical Examination and Follow Up Medical Care

- 16.1 Individuals who have not had a physical examination within one year (365 days) prior to admission shall have a physical examination within sixty (60) days following admission to the program.
  - 16.1.1 Results of the current physical examination shall be documented in the individual record.
  - 16.1.2 The current physical examination shall be reviewed, signed, and dated by the physician or other qualified medical personnel whose license allows them conduct and/or review physical examinations without oversight from a physician.
  - 16.1.3 Areas for wellness improvement identified as a result of exam, including any recommendations for follow-up primary or specialty medical care will be shared with the individual for possible inclusion in the individuals person directed recovery plan (PDRP) and will be documented in the individual record.
  - 16.1.4 The primary prescriber shall act as attending of record, holistically acknowledging all aspects of individuals health and wellness to provide care guidance to the team.
- 16.2 The ACT teams will assist individuals in maintaining optimal physical health to act or demonstrate efforts to function as a Health Home to individuals by assisting with:
  - 16.2.1 Scheduling annual physicals including lab work and testing as determined necessary by the physician;
  - 16.2.2 Making and keeping medical appointments;
  - 16.2.3 Transportation to medical appoints when:
    - 16.2.3.1 The individual is unable to independently attend appointments;
    - 16.2.3.2 Is unable to understand the advice of their medical doctor and is need of an advocate for medical care;
  - 16.2.4 Development of goals and objectives to address medical care in the individuals Person directed recovery plan.

## 17 Person-Directed Recovery Planning

17.1 Person directed recovery plans will be developed through the following recovery planning process:

17.1.1 The PDRP shall be developed in collaboration with the primary care manager, Peer and individual and:

17.1.1.1 his/her preferred natural supporters;

17.1.1.2 and/or guardian, if any, when feasible and appropriate;

17.1.1.3 treatment objectives provided by PROMISE care manager \*\*

17.2 The individual's participation in the development of the PDRP shall be documented; and ACT team shall evaluate together with each individual their:

17.2.1 strengths,

17.2.2 needs,

17.2.3 abilities, and

17.2.4 preferences.

17.3 The PDRP shall:

17.3.1 identify individual strengths and capacities;

17.3.2 identify individual service needs;

17.3.3 for each service need, set specific and measurable:

17.3.3.1 long- and short-term goals;

17.3.4 establish the specific approaches and interventions necessary for the individual to meet his/her goals,

17.3.5 improve his/her capacity to function as independently as possible in the community, and

17.3.6 seek to achieve the maximum level of recovery possible as defined by the individual (i.e., a meaningful, satisfying, and productive life) and

17.3.7 Identify interventions that have been helpful or that pose particular risks to the individual.

- 17.4 ACT team staff shall meet at regularly scheduled times for recovery planning meetings. The Team Leader shall conduct the recovery planning meetings.
- 17.5 ACT staff shall make every effort to ensure that the individual and his/her family and/or natural supports (if desired by the individual) are in attendance at the recovery planning meeting.
- 17.6 ACT staff shall invite other natural, peer, and/or professional supports (if desired by the individual) to attend in the recovery planning process (i.e. DSAAPD, methadone or other SUD treatment program(s), probation and parole, housing support programs, etc.).
- 17.7 ACT staff shall invite the PROMISE care manager to attend in recovery plan meeting. \*\*
- 17.8 Teams are responsible to provide the necessary support to ensure the individual is actively involved in the development of:
  - 17.8.1 Recovery and service goals; and
  - 17.8.2 Participation in the recovery plan meetings. This may include:
    - 17.8.2.1 offering of peer-based coaching and/or
    - 17.8.2.2 Skills training around his/her role in developing his/her own person directed recovery plan.
  - 17.8.3 With the permission of the individual, ACT team staff shall also involve pertinent agencies and members of the individual's social network in the formulation of recovery plans.
  - 17.8.4 Each individual's PDRP shall identify:
    - 17.8.4.1 service needs,
    - 17.8.4.2 strengths/barriers to success, and
    - 17.8.4.3 goals that are:
      - 17.8.4.3.1 specific and
      - 17.8.4.3.2 measurable.
  - 17.8.5 The PDRP must clearly specify:
    - 17.8.5.1 The approaches and interventions necessary for the individual to achieve the individual goals;
    - 17.8.5.2 The approaches and interventions that are contraindicated;

- 17.8.5.3 identify who will carry out the approaches and interventions
- 17.8.6 The following key areas should be addressed in every individual's PDRP unless they are explored and designated as deferred or referred, with signature by the individual:
  - 17.8.6.1 psychiatric illness management;
  - 17.8.6.2 symptom management;
  - 17.8.6.3 housing;
  - 17.8.6.4 IADL;
  - 17.8.6.5 daily structure and employment;
  - 17.8.6.6 family and social relationships;
  - 17.8.6.7 physical health; and
  - 17.8.6.8 other life areas, goals and aspirations as identified by the individual (e.g., community activities, empowerment, decision-making, educational goals and aspirations, economic improvements etc.)
- 17.8.7 The individual's own words are reflected in the recovery plan; which may at times include an attached copy of goals written by the consumer.
- 17.8.8 Measurable goals with current status.
- 17.9 The primary care manager and the team will be responsible for conducting a recovery plan review with the individual and their PROMISE care manager\*\*, during which the recovery goals and PDRP are rewritten or otherwise adjusted when there is a major decision point in the individual's course of treatment (e.g., significant change in individual's circumstances), and
  - 17.9.1 At a minimum of every one hundred and eighty (180) days.
- 17.10 The Team Leader shall prepare a summary in conjunction with every recovery plan review (recovery plan summary) which documents the individual's and the team's:
  - 17.10.1 Reasons for the review (regular review date or described change in circumstance);
  - 17.10.2 evaluation of his/her progress/goal attainment,
  - 17.10.3 evaluation of effectiveness of the interventions,
  - 17.10.4 satisfaction with services since the last recovery plan.

17.11 The revised recovery plan and recovery review summary will be signed by:

- 17.11.1 the individual,
- 17.11.2 the primary care manager,
- 17.11.3 the team leader, and
- 17.11.4 the psychiatric prescriber

17.12 A copy of the signed person directed recovery plan is made available to the individual.

## 18 Core ACT Services

18.1 Operating as a continuous treatment service, the ACT team shall have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit.

18.2 Services shall minimally include the following:

18.2.1 *Service Coordination* Each individual will be assigned a primary care manager who coordinates and monitors the activities of the individual's team and the greater ACT team. The responsibilities of the primary care manager are:

- 18.2.1.1 to work with the individual to write the person-directed recovery plan,
- 18.2.1.2 to provide individual supportive counseling,
- 18.2.1.3 to offer options and choices in the recovery plan,
- 18.2.1.4 to ensure that immediate changes are made as the individual's needs change, and
- 18.2.1.5 to advocate for the individual's wishes, rights, and preferences.
- 18.2.1.6 to act as principle contact and educator.

18.2.1.6.1 Members of the team share these tasks with the primary care manager and are responsible to perform the tasks when the primary care manager is not working.

18.2.1.7 to provide community liaison (Service coordination also includes coordination with community resources, including individual self-help and advocacy organizations that promote recovery.)

18.2.1.8 to incorporate and demonstrate basic recovery values in the coordination of services.

18.2.1.9 to help ensure the individual will have ownership of his or her own treatment and will be expected to:

18.2.1.9.1 take the primary role in person-directed recovery plan development;

18.2.1.9.2 play an active role in treatment decision making,

18.2.1.9.3 be allowed to take risks;

18.2.1.9.4 make mistakes and

18.2.1.9.5 learn from those mistakes.

### 18.3 Crisis Assessment and Intervention

18.3.1 Crisis assessment and intervention shall be provided 24 hours per day, seven days per week.

18.3.2 These services will include telephone and face-to-face contact.

18.3.3 Crisis Intervention, CAPAC, and CAPES programs as appropriate may provide adjunctive crisis intervention.

18.3.4 A representative from the ACT team will be directly available to support the ACT individual when external crisis responders are involved with the individual.

18.3.5 Each ACT individual will have an individualized, strengths based crisis plan that shall be updated annually.

18.3.6 The individual will take the lead role in developing the crisis plan.

18.4 *Symptom Management and Psychotherapy*: Symptom Management and Psychotherapy shall include but not be limited to the following:

18.4.1 Psycho-education regarding:

18.4.1.1 substance use and co-occurring disorders, when appropriate;

18.4.1.2 mental illness;

18.4.1.3 the effects of personal trauma history on mental health and recovery;  
and

18.4.1.4 the effects and side effects of prescribed medications, when appropriate.

18.4.2 Symptom management efforts directed to help each individual identify/target the symptoms and occurrence patterns of his or her mental illness and

18.4.3 Development of methods (internal, behavioral, or adaptive) to help lessen the effects.

18.4.4 Psychotherapy, including:

18.4.4.1 individual supportive therapy and empirically supported psychotherapy interventions that address specific symptoms and behaviors;

18.4.4.2 and family therapy when indicated by the BPS or PDRC, and informal support system.

18.4.5 Psychological support to individuals, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.

18.5 *Wellness Management and Recovery Services*: Wellness Management and Recovery Services shall include but not be limited to the following:

18.5.1 Defining and identifying the individual's recovery goals within the individual's frame of reference.

18.5.2 Developing strategies for implementing and maintaining the identified recovery goals as informed by the individual's strengths.

- 18.5.3 Psychoeducation and providing the individual with practical information about mental illness and the individual's diagnoses and experiences with mental illness.
- 18.5.4 Training in individual's legal rights, civil and human rights including rights under the ADA and Olmstead and how to access assistance in achieving these rights.
- 18.5.5 Skills training and practice:
  - 18.5.5.1 developing social supports;
  - 18.5.5.2 understanding and implementing individual coping skills to decrease stress;
  - 18.5.5.3 effectively using medication;
  - 18.5.5.4 developing a personal definition of relapse;
  - 18.5.5.5 identifying triggers for relapse and
    - 18.5.5.5.1 creating strategies for reducing relapse frequency and severity;
  - 18.5.5.6 identifying personal stressors and coping positively with those stressors.
  - 18.5.5.7 identifying and coping with symptoms.
  - 18.5.5.8 getting individual needs met within the mental health system, including empowerment and self-advocacy.
  - 18.5.5.9 learning and practicing new skills as they are developed with direct assistance.

## 19 Medication Prescription, Administration, Monitoring and Documentation

19.1 The ACT team's psychiatric prescriber shall:

- 19.1.1 Establish a direct and personal clinical relationship with each individual
- 19.1.2 Assess each individual's mental illness symptoms and provide verbal and written information about mental illness.
- 19.1.3 Review clinical information with the individual, and as appropriate, with the individual's family members or significant others;
- 19.1.4 Make an accurate diagnosis based on direct observation, available collateral information from the family and significant others and a current comprehensive assessment.
- 19.1.5 Provide a diagnostic work-up that will dictate an evidence-based medication pathway that the psychiatric prescriber will follow.
- 19.1.6 provide to the individual, and as appropriate, the individual's family and/or significant others, practical education about medication, including:
  - 19.1.6.1 benefits and
  - 19.1.6.2 risks of various medication strategies.
- 19.1.7 consider the preferences of the consumer with regard to medications that are incorporated in the individual's service plan;
- 19.1.8 devise a medication regimen that will help promote the consumer's engagement and ability to self-manage medications;
- 19.1.9 obtain informed consent from the individual for all medications prescribed.
- 19.1.10 In collaboration with the individual, assess, discuss and document the individual's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects.
- 19.1.11 Prescribers should provide care in a professionally responsible manner, adhering to the practice guidelines of the American Psychiatric Association, the American Medical Association, and the American Osteopathic Association.

19.2 All ACT team members shall assess and document the individual's behavior and response to medication and shall monitor for medication side effects.

19.2.1 Observations will be reviewed with the individual.

19.3 The ACT team program shall establish medication policies and procedures which identify processes to:

19.3.1 Record physician orders;

19.3.2 Order medication;

19.3.3 Arrange for all individual medications to be organized by the team and integrated into individuals' weekly schedules and daily staff assignment schedules.

19.3.4 Provide security for medications (e.g., long-term injectable, daily, and longer term);

19.3.5 Set aside a private designated area for set up of medications by the team's nursing staff.

19.3.6 Administer medications per Delaware Board of Nursing AWSAM protocols.

19.3.7 Apply for Patient Assistance Plan (PAP) for all individuals eligible for assistance.

## 20 Co-Occurring Disorders Services

20.1 ACT individuals with a positive screen for co-occurring substance use disorder shall receive an integrated mental health/substance use assessment during the first thirty (30) days of treatment. The assessment will include:

- 20.1.1 Substance use history;
- 20.1.2 Trauma history;
- 20.1.3 Parental and familial substance use summary;
- 20.1.4 Effects/impact of substance use;
- 20.1.5 Functional assessment: role played by substances in the individual's life;
- 20.1.6 Factors that have contributed to past successes and relapses;
- 20.1.7 Individual strengths;
- 20.1.8 Social support network (including both individuals who use substances and people who support recovery);
- 20.1.9 Individual's self-identified goals and aspirations;
- 20.1.10 ACT individuals will receive integrated treatment that is:
  - 20.1.10.1 non-confrontational,
  - 20.1.10.2 considers interactions of mental illness and substance abuse; and
  - 20.1.10.3 results in a person directed recovery plan that incorporates goals determined by the individual.

20.2 Treatment will follow a harm reduction model. This may include:

- 20.2.1 individual and/or group interventions in:
  - 20.2.1.1 developing motivation for decreasing use;
  - 20.2.1.2 developing skills to minimize use;
  - 20.2.1.3 recognition of negative consequences of use; and
  - 20.2.1.4 adoption of an abstinence goal for treatment.
- 20.2.2 Engagement (e.g., empathy, reflective listening).
- 20.2.3 Ongoing assessment (e.g., stage of readiness to change, individual-determined problem identification).

20.2.4 Motivational enhancement (e.g., developing discrepancies, psycho-education).

20.2.5 Active treatment (e.g., cognitive skills training, community reinforcement).

20.2.6 Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

## 21 Education Services:

21.1 *Supported Education:* Supported education related services are for ACT individuals whose high school, college or vocational education could not start or was interrupted and who wish to include educational goals in their recovery plan. Services provide support:

- 21.1.1 Enrolling and participating in educational activities;
- 21.1.2 Strengths-based assessment of educational interests, abilities and history;
- 21.1.3 Pre-admission counseling to determine which school and/or type of educational opportunities may be available;
- 21.1.4 If, indicated referral to GED classes and testing;
- 21.1.5 Assistance with completion of applications and financial aid forms;
- 21.1.6 Help with registration;
- 21.1.7 Orientation to campus buildings and school services;
- 21.1.8 Early identification and intervention with academic difficulties;
- 21.1.9 Linking with academic supports such as tutoring and learning resources;
- 21.1.10 Assistance with time management and schoolwork deadlines;
- 21.1.11 Supportive counseling;
- 21.1.12 Information regarding disclosing mental illness;
- 21.1.13 Advocating with faculty for reasonable accommodations.

## 22 Vocational Services:

22.1 *Vocational Services* shall be provided or coordinated to include work-related services to help individuals value, find, and maintain meaningful employment in ordinary community-based job sites as well as job development and coordination with employers. When the individual chooses to participate, services include but are not limited to:

22.1.1 Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.

22.1.2 Assessment of the effect of the individual's mental illness on employability with identification of specific behaviors that:

22.1.2.1 help and hinder the individual's work performance; and

22.1.2.2 development of interventions to reduce or eliminate any hindering behaviors and find effective job accommodations.

22.1.3 Job development activities.

22.1.4 Development of an ongoing employment rehabilitation plan to help each individual establish the skills necessary to find and maintain a job;

22.1.5 Provision of on-the-job or work-related crisis intervention services.

22.1.6 Other work-related supportive services, such as Supported Employment activities which may include: assistance with resume development, job application preparation, interview support, helping individuals with job related stress, managing symptoms while at work, grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation.

## 23 Instrumental Activities of Daily Living Services (IADLs)

23.1 These include services to support activities of daily living in community-based settings include:

- 23.1.1 individualized assessment,
- 23.1.2 problem solving,
- 23.1.3 skills training/practice,
- 23.1.4 sufficient side-by-side assistance and support,
- 23.1.5 modeling,
- 23.1.6 ongoing supervision (e.g. prompts, assignments, monitoring, encouragement),
- 23.1.7 environmental adaptations to assist individuals to gain or use the skills required to:

23.1.7.1 Find housing (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating;) which is:

- 23.1.7.1.1 safe,
- 23.1.7.1.2 good quality,
- 23.1.7.1.3 comfortable to the client,
- 23.1.7.1.4 affordable, and
- 23.1.7.1.5 in compliance with the *Americans with Disabilities Act* including the Olmstead Decision (28 C.F.R. § 35.130).

23.1.7.2 and procure necessities (such as telephones, furnishings, linens);

23.1.7.3 Perform household activities, including:

- 23.1.7.3.1 house cleaning;
- 23.1.7.3.2 Cooking;
- 23.1.7.3.3 grocery shopping; and
- 23.1.7.3.4 laundry.

23.1.7.4 Carry out personal hygiene and grooming tasks, as needed

23.1.7.5 Develop or improve money-management skills with the goal of attaining independence in management of one's finances

23.1.7.6 Use available transportation

23.1.7.7 Have and effectively use a personal physician and dentist.

## 24 Social and Community Integration Skills Training

- 24.1 Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skills training and include:
  - 24.1.1 supportive individual therapy (e.g., problem solving, role-playing, modeling, and support);
  - 24.1.2 social-skill teaching and assertiveness training;
  - 24.1.3 planning, structuring, and prompting of social and leisure-time activities;
  - 24.1.4 side-by-side support and coaching;
  - 24.1.5 organizing individual and group social and recreational activities to structure individuals' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:
    - 24.1.5.1 Improve communication skills,
    - 24.1.5.2 develop assertiveness, and increase self-esteem, as necessary
    - 24.1.5.3 increase social experiences,
    - 24.1.5.4 encourage development of meaningful personal relationships
    - 24.1.5.5 Plan productive use of leisure time
    - 24.1.5.6 Relate to landlords, neighbors, and others effectively
    - 24.1.5.7 Familiarize themselves with available social and recreational opportunities
    - 24.1.5.8 Enhance relationships with natural support systems
- 24.2 Housing Services – the team shall provide housing services, utilizing the supportive housing model. In addition to the housing-related IADL services outlined above, services include the following:
  - 24.2.1 Directly assisting individuals in locating housing of their choice, using a variety of housing options, including integrated, community-based, independent housing;
  - 24.2.2 Assistance in finding affordable, safe, and decent housing, which affords the individual rights of tenancy, whenever possible

## 25 Peer Support Services

25.1 These include services to validate individuals' experiences and to guide and encourage individuals to take responsibility for, and actively participate in their own recovery, as well as services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma. Peer Support and Wellness Recovery Services include:

25.1.1 Coaching in the development of Wellness Recovery Action Plan, and provision of other empirically supported peer-based, recovery approaches, such as Whole Health Action Management (WHAM) and Health and Recovery Peer Program (HARP)

25.1.2 Peer counseling and support services, including those which:

25.1.2.1 Promote self-determination and

25.1.2.2 Encourage and reinforce choice and decision making.

25.1.3 Introduction and referral to individual self-help programs and advocacy organizations that promote recovery.

25.1.4 Assist individuals in self-advocacy and self-directed treatment planning.

25.2 The Peer Specialist will serve as a full team member to support a culture of recovery in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, support, and community activities.

25.3 Peer staff shall not provide medication education, assistance with medication or be relegated to a position as a primary provider of transportation.

25.3.1 When it is determined that Peers are the best choice of staff on the ACT team to assist with medication adherence, the team must document the intervention in the person centered recovery plan and obtain permission from DSAMH prior to putting this practice in place;

25.3.1.1.1 The request from DSAMH shall contain information related to all other interventions attempted, the duration of how long the Peer shall provide the medication intervention, and other intervention

strategies that will be attempted to remove the peer from this role.

## 26 Psycho–education and Support of the Family and Supporters

26.1 Services provided or coordinated under this category to individuals' families and other major supports with individual agreement or consent, include:

- 26.1.1 Individualized psycho–education about the individual's illness and the role of the family in the therapeutic process;
- 26.1.2 Individualized psycho–education about the individual's illness and the role of other significant people in the therapeutic process;
- 26.1.3 Family intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people;
- 26.1.4 Ongoing communication and collaboration, face–to–face and by telephone, between the ACT team and the family;
- 26.1.5 Introduction and referral to family self–help programs and advocacy organizations that promote recovery;
- 26.1.6 Assistance to individuals with their children, including individual supportive counseling, parenting training, and service coordination but not limited to:
  - 26.1.6.1 Services to help individuals throughout pregnancy and the birth of a child;
  - 26.1.6.2 Services to fulfill parenting responsibilities and coordinating services for the child;
  - 26.1.6.3 Services to restore relationships with children who are not in the individual's custody.

## 27 Documentation of Services

27.1 The ACT team will document all services provided to individual and family in the individual file.

27.1.1 In addition to documentation of each contact, a narrative summary of the services provided to the individual shall be entered into the individual chart monthly shall be in accordance to best practice and include:

27.1.1.1 A minimum of sixty (60) minutes of service/week with a minimum of three (3) contacts/week based on the PDRP that reflects medical necessity. If a less intense level of service is provided to an individual over the course of a six-month period, due to the persons' recovery progress, the ACT team will document that it is implementing a timely process of assisting the individual in making the transition to a lower level of care;

27.1.1.2 services provided and the individual's response to those services provided;

27.1.1.3 Progress in meeting recovery plan goals;

27.1.1.4 Coordination and Communication related to consumers care;

27.1.1.5 Changes in recovery plan goals;

27.1.1.6 Plans for continuation of care during the coming month;

27.1.1.7 Is signed and dated by the person entering the note into the individual chart.

## 28 FACILITY STANDARDS

28.1 The facility(ies) within which the ACT team(s) operate shall meet the following criteria:

- 28.1.1 They shall post a Certificate of Occupancy;
- 28.1.2 They shall meet all applicable fire and life safety codes;
- 28.1.3 They shall be maintained in a clean and safe condition;
- 28.1.4 They shall provide rest rooms maintained in a clean and safe condition available to individuals, visitors and staff;
- 28.1.5 They shall be accessible to the individual served;
- 28.1.6 They shall provide a smoke free environment.

## 29 Individual Rights and Grievance Procedures

29.1 ACT teams shall be knowledgeable about and familiar with individual rights including the clients' rights to:

- 29.1.1 Confidentiality
- 29.1.2 Informed consent to medication and treatment
- 29.1.3 Treatment with respect and dignity
- 29.1.4 Prompt, adequate, and appropriate treatment
- 29.1.5 Treatment which is under the least restrictive conditions and which promotes individuals' meaningful community integration and opportunities to live like ordinary Delawareans;
- 29.1.6 Nondiscrimination;
- 29.1.7 Control of own money;
- 29.1.8 Voice or file grievances or complaints.

29.2 ACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce individual rights. These include:

- 29.2.1 Grievance or complaint procedures under:
  - 29.2.1.1 Medicaid;
  - 29.2.1.2 DSAMH;
  - 29.2.1.3 *Americans with Disabilities Act*.
  - 29.2.1.4 Delaware Human Rights Commission and U.S. Department of Justice (Human Rights).
  - 29.2.1.5 U.S. Department of Housing and Urban Development (HUD–housing discrimination.)
  - 29.2.1.6 PROMISE Care Manager\*\* (see Manual)

29.3 ACT teams shall be prepared to assist individuals in filing grievances with the appropriate organizations and shall:

- 29.3.1 Have a grievance policy and procedure posted in a conspicuous and prominent area that includes:

29.3.1.1 the names and phone numbers of individuals who can receive grievances both at the agency and with other organizations in §30.2 of these standards;

29.3.1.2 A standardized process for accepting and investigating grievances;

29.3.2 Maintain documentation of the investigation and resolution of all grievances and;

29.3.2.1 Provide for its availability to DSAMH upon request.

29.4 ACT teams should ensure that individuals receive from all staff members' effective, understandable and respectful care that is provided in a manner compatible with their cultural identity, gender, gender expression, sexual orientation, age, faith beliefs, health beliefs and practices.

29.5 ACT teams will also ensure that individuals receive services in their chosen language when their primary language is not English. Teams will make arrangements for interpreter services as required by federal law.

### 30 ADMINISTRATIVE STANDARDS

#### 30.1 Individual Records

30.1.1 There shall be a treatment record for each individual that includes sufficient documentation of assessments, recovery plans and treatment to justify Medicaid participation and to permit a clinician not familiar with the individual to evaluate the course of treatment.

30.2 There shall be a designated individual records manager who shall be responsible for the maintenance and security of individual records.

30.3 The record-keeping format and system for purging shall provide for consistency, and facilitate information retrieval.

30.4 Individual treatment records shall be kept confidential and safe-guarded in a manner consistent with the requirements of *the Health Insurance Portability and Accountability Act* of 1996, 45 C.F.R. Parts 160 and 164, and 42 C.F.R Part 2 governing the confidentiality of alcohol and drug patient records (if applicable).

30.5 The individual treatment record shall be maintained by the organization a minimum of seven (7) years after the discharge of the individual.

30.6 The active individual record shall contain the following:

30.6.1 A minimum of the program's last twelve (12) months treatment records for the individual; (Note: when individual records are kept in multiple charts, twelve (12) months of records shall be readily available on site.)

30.6.2 An up-to-date face sheet:

30.6.2.1 Date of Admission

30.6.2.2 Guardian and Contact Information

30.6.2.3 Emergency Contacts and Information

30.6.2.4 Allergies

30.6.2.5 Diagnoses

30.6.2.6 Family/Natural Supports

30.6.2.6.1 Contact Information

- 30.6.2.7 Treating Psychiatrist and Contact Information
- 30.6.2.8 Primary Care Physician and Contact Information
- 30.6.2.9 Existence of Advanced Directive and/or Psychiatric Advanced Directive
  - 30.6.2.10 Individual's Address and Phone Number
  - 30.6.2.11 Photo of the Individual
  - 30.6.2.12 Date of Birth
  - 30.6.2.13 MCI Number
  - 30.6.2.14 Insurance
  - 30.6.2.15 Race, Ethnicity, Gender
- 30.6.3 Consent to treatment signed by the individual;
- 30.6.4 Consent to any occasion of release of information;
- 30.6.5 Documentation that the individual has been informed of his/her rights and the consumer's level of understanding of these rights;
- 30.6.6 Documentation that the individual has been provided with information regarding the process by which grievances can be addressed;
- 30.6.7 Reports from all examinations, tests and clinical consults;
- 30.6.8 Hospital discharge summaries;
- 30.6.9 Comprehensive medical psychosocial evaluation;
- 30.6.10 Comprehensive recovery plan development, review of recovery plan, and updates to recovery plan;
- 30.6.11 Crisis intervention plan and updates;
- 30.6.12 The consumer's Advance Directive or other documentation of measures to be taken in the event of incapacity
- 30.6.13 Summary of monthly individual activity;
- 30.6.14 Progress notes;
- 30.6.15 Documentation of case review with clinical supervisor;
- 30.6.16 Medication records;
- 30.6.17 Discharge documentation.

### 31 Performance Improvement Program

- 31.1 The ACT programs shall prepare an annual performance improvement plan, which shall be subject to approval by the Division. A clinician employed by the program or parent organization shall be designated performance improvement coordinator. The provider shall establish the performance improvement mechanisms below which shall be carried out in accordance with the performance improvement plan:
- 31.1.1 A statement of the program's objectives. The objectives shall relate directly to the program's individuals or target population.
  - 31.1.2 Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
  - 31.1.3 Methods for documenting achievements related to the program's stated objectives.
  - 31.1.4 Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
  - 31.1.5 In addition to the performance improvement and program evaluation plan, the ACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.
  - 31.1.6 The ACT team shall maintain performance improvement and program evaluation policies and procedures that include:
    - 31.1.6.1 a concurrent utilization review process;
    - 31.1.6.2 a retrospective performance improvement review process;
    - 31.1.6.3 a process for clinical care evaluation studies; and
    - 31.1.6.4 a process for self-survey for compliance with the certification standards and fidelity standards as prescribed by the Division.
- 31.2 The ACT team(s) shall ensure that data on the individual's race, ethnicity, spoken and written language, sexual orientation, and gender expression are collected in health records, integrated into the organization's management information systems, and are periodically updated.

31.3 The ACT team(s) shall use the data outlined in §32.2 of these standards to develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and individual involvement in designing and implementing culturally aware activities and services that reflect the population that the program serves.

31.4 Certified and/or Certified and Contracted Providers will undergo, in most cases, a simultaneous contract review and certification by the DSAMH Monitoring (QA) team.

31.4.1 More than three (3) deficiencies from Certification Review, may not receive a full year Certification with determination rendered by QA Supervisor and DSAMH Administration;

31.4.2 Providers with several deficiencies from Contract Review, this may affect the length of the Certification. Providers are expected to follow the specific scopes as deemed in the Contract.