

PROVIDER CERTIFICATION MANUAL
FOR
COMMUNITY SUPPORT SERVICES PROGRAMS

Assertive Community Treatment
(ACT)

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

Version IV

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 diagnoses and functional needs. DSAMH certification is required for provider enrollment with the Division of Social Services, and 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, DSAMH 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 DMMA 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 treatments, rehabilitative services, and support services for persons with mental illness and substance use disorders. Assertive Community Treatment (ACT), is a community support program that the Division certifies as part 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 (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 regarding 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 DSAMH 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 direct service staff, as defined by the Tool for Measurement of Assertive Community Treatment (TMACT), who collectively 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 the beneficiary and his/her family and/or natural supports in the community by the time of the first assessment and subsequent person-directed recovery planning meeting. The ACT team size may range from 70 to 125 beneficiaries with staffing maintained at the DSAMH-approved TMACT ratio of 1:10.

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

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

Beneficiary – Is an adult, age eighteen (18) and older that is receiving person-centered treatment, rehabilitation, and support services from the ACT team.

Biopsychosocial (BPS) – Is an assessment based on the understanding that biological, psychological, and social factors are related as significant factors in human functioning in the context of disease or illness.

Certified Mental Health Screener – is a licensed professional, or an unlicensed professional under the direct supervision of a psychiatrist, who has completed the DSAMH credentialing process, and is certified to detain or revoke the detention of an individual for psychiatric assessment.

Certified Peer Recovery Specialist (CPRS) – is an individual with personal, lived experience with their own recovery, who has completed the process for certification. The role of the CPRS uses a

collaborative and strength-based approach, with the primary goal of assisting beneficiaries in achieving sustained recovery from the effects of mental health and/or substance use issues.

Certified Peer Recovery Support Services – Are services provided by team members who have experience as recipients of mental health and/or substance use services. The role of the peer support specialist includes providing services that help to validate beneficiaries’ experiences, provide guidance and encouragement to beneficiaries to take responsibility for, and actively participate in, their own recovery, help beneficiaries identify, understand, and combat stigma and discrimination against mental illness, and develop strategies to reduce beneficiaries’ self-imposed stigma. The SAMHSA Core Competencies for Peer Workers in Behavioral Health Services shall be the guide for utilizing these services.¹

Certified Supervisor of Peer Specialists (CSPS) is a person who is providing direct supervision to certified peer recovery specialists and has completed the process to become certified as a supervisor.

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

Comprehensive Assessment – Is the organized process of gathering and analyzing current and past information with each beneficiary and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) presence of any substance use disorders; 3) effectiveness of past treatment; 4) current treatment, rehabilitation, and support needs to achieve individual goals and support recovery; and, 5) the range of individual strengths (e.g., knowledge gained from dealing with adversity, personal/professional roles,

¹ <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers>

talents, personal traits) that can act as resources to the beneficiary and his/her PDRP 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 beneficiary; 2) set goals and develop the first PDRP with each beneficiary; and, 3) optimize benefits that can be derived from existing strengths and resources of the beneficiary and his/her family and/or natural support network in the community.

Co-Occurring Disorders (COD) Services – Includes integrated assessment and treatment for beneficiaries who have co-occurring mental health and substance use conditions.

Crisis Assessment and Intervention – Includes services offered twenty-four (24) hours per day, seven days per week, for beneficiaries experiencing an event that requires immediate response from a team member or other mental health professional. This includes active collaboration and physical presence at local emergency departments and state crisis response settings.

Daily Log – Is a written document maintained by the ACT team on a daily basis to provide: 1) a current roster of beneficiaries served by the team; and, 2) for each beneficiary, a brief description of any treatment or service contacts which have occurred during the day, a concise behavioral description of the beneficiary'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 beneficiaries; 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 PDRPs 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 Department of Health and Social Services.

DMMA – Refers to the 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 Division of Substance Abuse and Mental Health within the Department of Health and Social Services.

DVR – Refers to the Division of Vocational Rehabilitation.

Eligibility and Enrollment Unit (EEU) – Ascertains initial eligibility for PROMISE services, provides authorizations for services, assists with hospital placements, and handles appeals. Individuals who wish to enroll in PROMISE must apply for services through the EEU. The EEU evaluates each individual's need for services based on a variety of criteria such as diagnosis, history of mental illness and/or substance abuse, history of previous hospitalizations, and the ability to successfully function in the community.

Family and Natural Supports Psychoeducation – 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.

Illness/Symptom Management – Is an approach directed to help individuals identify and target the undesirable symptoms and disruptive manifestations of his or her mental illness, and to develop methods aimed at reducing recurrence and impact of those symptoms. Methods include identifying triggers and warning signs and learning ways to prevent and cope with symptoms.

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 help individuals understand and identify symptoms, develop 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 beneficiary understands 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 (PDRP) – Is the initial evaluation of: 1) the beneficiary’s mental and functional status; 2) the presence of any substance use disorders; 3) the effectiveness of past PDRPs; 4) the current treatment, rehabilitation and support service needs, and 5) 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 PDRP, detailing the beneficiary’s goals. Note that the beneficiary is formally admitted as of the date of the initial assessment. The beneficiary’s initial assessment and PDRP guides team services until the comprehensive assessment, and full PDRP is completed. If information obtained later in the comprehensive assessment indicates the beneficiary needs a different level of care, the program must maintain the beneficiary until changes are approved by PROMISE.

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

Interdisciplinary Approach – Is the service model where team members from multiple disciplines systematically collaborate and train each other in the methods associated with their expertise, to integrate each member’s unique point of view. The purpose of this approach is to share responsibility for services, so beneficiaries receive the specific evidence-based and client-centered services they need. The communication expectation in this type of team involves continuous collaboration among all members (inclusive of the beneficiary and, if desired, his/her family/other natural supports) on a regular, planned basis.

Limited Lay Administration of Medications (LLAM) – is a system whereby unlicensed personnel are trained to assist in the administration of medications. A designated care provider who has taken Board-approved LLAM training, or a designated care provider who is otherwise exempt from the requirement of having to take the Board-approved LLAM training, 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 beneficiary 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. When delivering medications to the beneficiary 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. LLAM Rules and Regulations may be found in Section 5 of the Board of Nursing Rules and Regulations (<http://regulations.delaware.gov/AdminCode/title24/1900.shtml>).

Medication Administration – Is the physical act of giving medication to beneficiaries in an ACT program by the prescribed route 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 beneficiary or the beneficiary'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, licensed practical nurse or psychiatric prescriber, all team members must receive Limited Lay Administration of Medications (LLAM) training at the beginning of employment, and annually 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 beneficiary adhere to a prescribed medication regimen; this allowance must be time-limited, along with a plan to disengage the peer from providing this service, and is subject 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 beneficiary, the psychiatric prescriber, and team, to: provide training in medication adherence; to carefully evaluate the beneficiary’s previous experience with psychotropic medications and side effects; to identify and discuss the benefits and risks of psychotropic and other medications; 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.

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

Primary Case Manager – Under the supervision of the Team Leader, the primary case 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 beneficiary on a continual basis, whether the beneficiary 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 beneficiary’s life, circumstances, and goals and desires.

The primary case manager develops and collaborates with the beneficiary to write the PDRP, offers options and choices in the PDRP, ensures that immediate changes are made as the beneficiary’s needs change, and advocates for the beneficiary’s wishes, rights, and preferences.

The primary case manager also works with other community resources, including individually-run services, to coordinate activities and integrate other agency or service activities into the overall PDRP with the beneficiary. The primary case manager provides support and education to the family and/or support system, and other significant people. In most cases, the primary case manager is the first team member available to the beneficiary in crisis. The primary case manager shares these service activities with other members of the team who are responsible to perform them when the primary case manager is not working.

Program – Refers to the ACT team that provides service in accordance with these standards.

PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) – Is a program within DSAMH that provides an array of services to beneficiaries meeting specific diagnostic and functional criteria, with a focus on person-centered, recovery-oriented, and community-focused supportive services.

PROMISE Care Manager – Is a conflict-free advocate to a beneficiary in receipt of ACT services, ensuring assessment, recovery plan development, facilitating access and referral to needed services, and monitoring the delivery and quality of services consistent with the beneficiary's PROMISE Recovery Plan; a plan separate from the ACT PDRP.

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 with mental health diagnoses and have full privileges to diagnose 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.

PDRP Review – Is a thorough, written summary describing the beneficiary's, and the interdisciplinary team's, evaluation of the beneficiary's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last PDRP. The PDRP review provides a basis for making needed refinements in the beneficiary's service plan and

includes active participation by the beneficiary served, as well as any natural supports identified by the beneficiary who are willing to participate.

PDRP 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 beneficiary and his/her family/natural supports 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 beneficiary’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 beneficiary and his/her goals and aspirations, and for each beneficiary 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 PDRP rationale in order to carry out the plan for each goal.

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

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 a competitive or customized, integrated work setting that meets job and career goals, including self-employment, which provides compensation at or above the

minimum wage, in line with compensation to employees with the same or similar work by individuals without disabilities.

TMACT – Is the Tool for the Measurement of Assertive Community Treatment Teams.

Trauma-Informed – Is when organizations, programs, and services are based on an understanding of the vulnerabilities of triggers of trauma survivors that traditional service 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 their 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 – Includes work-related services to help beneficiaries find, value, 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 beneficiary 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 to meet medical necessity for program services. This includes having a qualifying severe and persistent mental health condition as per PROMISE criteria. The following tools are used for documentation of medical necessity. Specific PROMISE diagnostic criteria can be found in Appendix A.

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.

3.1.2.1.1.2 Interpersonal functioning;

3.1.2.1.1.3 Concentration, persistence, and pace;

3.1.2.1.1.4 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 Beneficiary 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:
 - 3.1.3.1.1 Evidence that one of the criteria in §3.1.1, §3.1.2, and §3.1.3 are met;
 - 3.1.3.1.2 The reasons for admission as stated by both the beneficiary and the team;
 - 3.1.3.1.3 The signature of the psychiatric prescriber.
- 3.1.4 The ACT Team will need to make the first contact with a client within 48 to 72 hours once a client is referred to the program. This is to include scheduling the client’s first appointment in accordance with 3.1.5.
- 3.1.5 Admission into the ACT team shall be completed within ten (10) business days from the date of the referral.
 - 3.1.5.1 All and any attempts made to complete 3.1.4 and 3.1.5 must be documented in detail.

3.1.5.2 Any exceptions to first contact or admission must be reported to the EEU; and

3.1.5.3 Upon request, all documentation shall be provided to DSAMH/EEU.

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. This will include the review of all relevant documentation prior to the admission (e.g. hospital records, and other clinical documentation of supports).

3.2 Requests for Discharge from services shall occur when a beneficiary:

3.2.1 Has successfully reached individually established goals and demonstrates an ability to function in all major role areas such as work, social activities, and self-care, and when the beneficiary and program staff mutually agree 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 beneficiary is moving. The ACT team shall maintain contact with the beneficiary 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, and when the beneficiary, PROMISE Care Manager, and program staff mutually agree to the transition from ACT to less intensive services;

3.2.4 Is receiving less than the minimum monthly contacts of three face-to-face contacts per week, at an average of two (2) hours per week or more;

3.2.4.1 If this is due to the beneficiary's increased independence, there should be evidence in the PDRP that there is a plan for the beneficiary to step down to a lower level of care;

3.2.4.2 If this is because the beneficiary is not engaging, the PDRP should show evidence of attempts to reengage the beneficiary;

3.2.4.3 No beneficiary should remain with the ACT team longer than 90 consecutive days, if receiving less than the minimum contact per month.

3.2.5 Declines or refuses services and requests discharge, despite the team's documented best efforts to utilize appropriate engagement techniques to develop a mutually-acceptable PDRP with the beneficiary;

- 3.2.5.1 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 beneficiary prior to the discharge of an beneficiary from ACT services.
- 3.2.6 In addition to the discharge criteria listed above, based on mutual agreement between the beneficiary and ACT staff, an individual discharge may also be facilitated due to any one of the following circumstances:
 - 3.2.6.1 Death;
 - 3.2.6.2 Inability to locate the beneficiary despite documented active outreach efforts by the team for a period of ninety (90) continuous days;
 - 3.2.6.3 Incarceration of ninety (90) days or more;
 - 3.2.6.4 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 beneficiary will not be appropriate for discharge from the hospital or nursing facility for a prolonged period of time.
- 3.2.7 If the beneficiary is accessible at the time of discharge, the team shall ensure beneficiary participation in all discharge activities, or document all attempts to obtain signature.
- 3.2.8 The discharge summary shall include:
 - 3.2.8.1 Date of discharge;
 - 3.2.8.2 Reason for discharge;
 - 3.2.8.3 Beneficiary's status upon discharge based on the most recent assessment;
 - 3.2.8.3.1 DSM diagnosis;
 - 3.2.8.3.2 Summary of progress toward meeting goals as set forth in the beneficiary's PDRP;
 - 3.2.8.3.3 Documentation of the team's efforts to engage the beneficiary in services, when relevant to the reason for discharge;
 - 3.2.8.3.4 Aftercare/follow-up plan completed in conjunction with the beneficiary;

- 3.2.8.3.5 Collaboration with Medicaid Care Organization or other insurance provider;
- 3.2.8.3.6 The beneficiary's contact information (e.g., forwarding address and/or phone number, email address).
- 3.2.8.4 The discharge summary shall be:
 - 3.2.8.4.1 Completed within five (5) business days of discharge from the ACT team;
 - 3.2.8.4.2 Signed and dated by:
 - 3.2.8.4.2.1 The beneficiary when the discharged is planned;
 - 3.2.8.4.2.2 The primary care manager;
 - 3.2.8.4.2.3 The physician;
 - 3.2.8.4.2.4 The team leader.
- 3.2.9 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-Beneficiary Ratio:

- 4.1.1 Each ACT team shall have the organizational capacity to provide a staff-to-beneficiary ratio of one (1) full-time equivalent (FTE) staff person for every ten (10) beneficiaries served by the team;
 - 4.1.1.1 Distinct ACT teams are required.
- 4.1.2 The maximum number of beneficiaries being served by any one ACT team is one hundred twenty-five (125).

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 beneficiary and the provider.
 - 4.3.1.1.1 Frequency should be a minimum of three (3) face-to-face contacts per week at an average of two (2) hours per week or more.

- 4.3.2 The ACT team shall have the capacity to provide contacts per week that avail sufficient support with beneficiaries 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 can be as frequent as three to four times per day, seven days per week. All team members (team leader, psychiatric prescriber, and other assigned staff) shall share responsibility for addressing the needs of all beneficiaries requiring frequent contact, as appropriate. The only exception to this is the program assistant.
- 4.3.3 The following services, as deemed necessary by DSAMH-approved assessment tools, and detailed in the PDRP, will be provided:
- 4.3.3.1 Psychiatric and substance abuse treatment;
- 4.3.3.1.1 Psychiatric prescriber: Face-to-face evaluation, at a minimum of 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 at a minimum of every fourteen (14) days for the first sixty (60) days after admission, and then as prescribed in the PDRP that details an on-going SUD evaluation schedule that is appropriate to the severity of the SUD.
- 4.3.3.1.3 Availability of supportive mental health counseling, or evidenced-based interventions provided by a Master's level clinician.
- 4.3.3.2 Medication monitoring as follows:
- 4.3.3.2.1 The psychiatric prescriber will explain to the beneficiary (in language understandable to the beneficiary) 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 annually, at a minimum.
- 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 beneficiary'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 beneficiaries 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 Record (MAR) that 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 beneficiary adherence to 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;
 - 4.3.3.2.5.2.1.2 Laboratory reports shall:
 - 4.3.3.2.5.2.1.2.1 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 beneficiary's chart within 30 days, or sooner, as clinically warranted to reduce danger to life or physical safety of clients or others.
 - 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 beneficiaries at risk for developing Tardive Dyskinesia.
- 4.3.3.2.5.2.3.2 Annual screening for metabolic disorders in beneficiaries prescribed atypical antipsychotic medications.
- 4.3.3.2.5.2.4 Education of beneficiaries 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 beneficiaries taking atypical antipsychotic medications (including, but not 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 assessments;
 - 5.1.1.3 Trauma informed interventions;
 - 5.1.1.4 Crisis assessment and intervention, including the ability to perform a psychiatric detention;
 - 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 beneficiaries obtain the basic necessities of daily life;
 - 5.1.1.14 Education, support, and consultation to beneficiaries' families and other major supports; and
 - 5.1.1.15 Services that meet the requirements of the ADA/Olmstead Act and their implications for practice.
- 5.1.2 The staff should have sufficient representation and cultural competence in the local cultural population that the team serves.

6 ACT Team Size and Composition

- 6.1 The program shall employ a low consumer to staff ratio as referenced in the most recent DSAMH-approved version of TMACT.
- 6.2 Mental Health Professionals on Staff
 - 6.2.1 The number of interdisciplinary clinical staff positions on an ACT team is determined by DSAMH-approved TMACT.
 - 6.2.1.1 Mental health professionals are individuals with:
 - 6.2.1.1.1 Professional degrees (Master's 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 The required number of mental health professionals for an ACT team is clearly delineated in the DSAMH-approved TMACT.

7 ACT Required Staff

- 7.1 DSAMH-approved TMACT protocol describes requirements of core job positions that must be present: team lead, vocational specialist, chemical dependency, certified peer recovery specialist, psychiatric nurses, psychiatric prescriber, and a dedicated office assistant. The program has discretion to determine which positions require the Master's level requirement versus Bachelor's requirement.
- 7.2 The following provides a description of and qualifications for required staff on an ACT team:
 - 7.2.1 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 beneficiaries at least six (6) hours per week.
 - 7.2.2 Psychiatric Prescriber – The psychiatric prescriber may include:
 - 7.2.2.1 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.
 - 7.2.2.2 A Delaware Licensed and Certified Psychiatric Nurse Practitioner who is permitted to diagnosis mental health disorders and prescribe psychotropic medications for such disorders, and who practices under a collaborative agreement with a Delaware licensed psychiatrist, as prescribed in the Board of Nursing Regulations.
 - 7.2.2.3 The psychiatric prescriber works the required hours per the DSAMH-approved TMACT ratio defined for the size of the team. The psychiatric prescriber provides clinical support to all ACT beneficiaries; works with the team leader to monitor each beneficiary's clinical status and response to treatment; supervises

staff delivery of services; and directs psychopharmacologic and medical services.

7.2.3 Registered Nurses – All registered nurses shall be licensed in the State of Delaware or participating in the Nurse Licensure Compact (NLC). At least one Registered Nurse must have one year’s experience working with adults with severe mental illness.

7.2.4 Master’s Level Mental Health Professionals – Minimum of two (2) FTE Master’s level or above mental health professionals is required on each ACT team, which can include the Team Leader.

7.2.5 Chemical Dependency Specialist* – At least one FTE team member must be a dedicated Chemical Dependency Specialist, meaning the identified staff person cannot also function in another primary role as well. Delaware uses the term Chemical Dependency Specialist as equal to the TMACT Co-Occurring Specialist requirement.

7.2.5.1 Chemical Dependency Specialists may be one of the Master’s Level or Bachelor’s level clinicians on the team.

7.2.5.1.1 Certification by the State of Delaware as a Certified Alcohol and Drug Counselor (CADC) or Certified Advanced Alcohol and Drug Counselor (CAADC); or

7.2.5.1.2 At least three (3) years of supervised work experience in the substance abuse treatment field; and,

7.2.5.1.3 Enrollment and completion of CADC or CAADC within eighteen (18) months of hire.

7.2.6 Certified Peer Recovery Specialist (CPRS)* – A minimum of one (1) FTE CPRS is required on an ACT team. Because of his/her life experience with mental illness, substance use, co-occurring disorders, and related services, the CPRS 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 beneficiary self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each beneficiary's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities.

7.2.7 Remaining Clinical Staff - The remaining clinical staff will include Bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions. TMACT does not specify a housing specialist, though does indicate the need for housing support. Delaware does require that a housing specialist be a part of the ACT team. It is recommended that this person have 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 assistance payments.

7.2.7.1 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.

7.2.7.2 A paraprofessional mental health worker may have:

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

7.2.7.2.2 A high school diploma and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs and have at least two (2) years of experience. Paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience of at least two (2) years.

7.2.8 Vocational Specialist* – Each team will make available one vocational specialist with training and experience in vocational services at a minimum of one (1) year experience. The vocational specialist can be one of the Bachelor-level positions on the team. The vocational specialist will be available for face-to-face meetings with the beneficiary served.

*The Specialist title requires 80% of their work be dedicated to that role (Chemical Dependency, Peer, and Vocational titles).

8 Policy and Procedure Requirements:

8.1 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:

- 8.1.1 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.
- 8.1.2 Referral policies and procedures that facilitate beneficiary referral;
- 8.1.3 Detailed procedures for assessment, recovery planning, and documentation;
- 8.1.4 Policies and procedures for medication management in compliance with all applicable rules, regulations and requirements of the Delaware Division of Professional Regulation, the Delaware Board of Nursing, and the Delaware Board of Pharmacy (if applicable) to include policies and procedures for:
 - 8.1.4.1 Prescribing medication;
 - 8.1.4.2 Storage of medication;
 - 8.1.4.3 Handling of medication;
 - 8.1.4.4 Distribution of medication;
 - 8.1.4.5 Recording of medication used by beneficiaries;
 - 8.1.4.6 Assistance with medication, in accordance with LLAM.
- 8.1.5 Policies and procedures for handling on-call responsibilities and individual emergencies, including, but not limited to:
 - 8.1.5.1 Policies and procedures for accessing and documenting the need for outside consultation to further the service goals or clinical needs or beneficiaries;
 - 8.1.5.2 Detailed instructions for application to, and communication with, entitlement authorities including, but not limited to:
 - 8.1.5.2.1 The Social Security Administration;
 - 8.1.5.2.2 Social Services (SNAP, WIC, general relief, energy assistance, etc.)
 - 8.1.5.5.3 State Rental Assistance Program (SRAP), HUD/Section 8
 - 8.1.5.5.4 Medicaid;
 - 8.1.5.5.5 Medicare;

- 8.1.5.5.1 Low Income Subsidy (LIS)
- 8.1.5.5.2 Part D Medicare
- 8.1.5.5.6 Prescription Assistance Program (PAP)
- 8.1.5.5.7 Representative Payee (when applicable)
- 8.1.5.3 Policies and procedures for obtaining releases to share Protected Health Information about beneficiaries with family members or others;
- 8.1.5.4 Policies and procedures regarding communicating and handling financial resources of the program;
- 8.1.5.6 Policies and procedures regarding the coordination of financial activities with the beneficiary's representative payee for payment from the Social Security Administration;
- 8.1.5.7 Policies and procedures for the receipt and resolution of beneficiary complaints and/or grievances related to the quality of services provided by the ACT program including, but not limited to,: quality of care, access to services provided for in a person's PDRP, staff attitude and service, financial issues, or other program activities where the beneficiary feels that he or she has not received considerate, respectful and appropriate care, or treatment or services that are not compliant to relevant federal and state laws and regulations, recognizing each person's basic personal and property rights, which include dignity and individuality. Failure to file a grievance or request an investigation following the request by the beneficiary may be grounds for corrective action. All grievances must be reported to the PROMISE Administrator and/or Clinical Services Administrator for the appropriate county. If person has a change or reduction in a Medicaid-reimbursable service(s) that requires a fair hearing, the ACT program's internal policy and procedures for grievance resolution shall not take the place of the required fair hearing or in any way delay or infringe upon the person's right to a fair hearing.
- 8.1.5.8 Policies and procedures for reporting the following, but not limited to: instances of death, possible abuse or neglect, and other Critical or General Incidents to DHSS/DSAMH, law enforcement, and other entities in accordance with state and federal regulations and laws;
- 8.1.5.9 Policies and procedures for assisting consumers in securing legal counsel or other special professional expertise when needed;

- 8.1.5.10 Policies and procedures for ensuring that consumers are not subject to unwarranted coercion, including legal coercion (outpatient commitment, guardianship);
- 8.1.5.11 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;
- 8.1.5.12 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.

9 Personnel Management

- 9.1 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:
 - 9.1.1 Policies and procedures regarding equal employment opportunity and affirmative action to include compliance with:
 - 9.1.1.1 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;
 - 9.1.1.2 Title XIX of Del section 711 prohibiting discrimination on the basis of race, color, creed, sex, sexual orientation, and national origin;
 - 9.1.1.3 Age discrimination Act of 1975 prohibiting discrimination based on age;
 - 9.1.1.4 Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974 prohibiting discrimination against disabled Vietnam Era veterans.
 - 9.1.2 Policies and procedures for interviews and selection of candidates including:
 - 9.1.2.1 Verification of credentials and references;
 - 9.1.2.2 Criminal background checks including:
 - 9.1.2.2.1 Registration on Adult Abuse and Child Abuse registries;

- 9.1.2.3 Policies and procedures for employee performance appraisal including;
- 9.1.2.4 A code of ethics;
- 9.1.2.5 Conditions and procedures for employee discipline, including termination of employment;
- 9.1.2.6 Conditions and procedures for employee grievances and appeals;
- 9.1.2.7 An annual staff development plan which shall include:
 - 9.1.2.7.1 Provisions for orientation of paid staff, student interns and volunteers. Orientation shall include:
 - 9.1.2.7.1.1 Review of these standards;
 - 9.1.2.7.1.2 Review of the program's Procedures and Personnel manuals;
 - 9.1.2.7.1.3 Limited Lay Administration of Medication (LLAM) in accordance with Delaware Nurse Practice Act, and applicable rules and regulations;
 - 9.1.2.7.1.4 Review of DHSS Policy Memorandum #46;
 - 9.1.2.7.1.5 Review of section 5161 of Title 16 of the Delaware Code;
 - 9.1.2.7.1.6 Review of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164;
 - 9.1.2.7.1.7 Review of the Substance Abuse Confidentiality regulations codified at 42 C.F.R. Part 2.
 - 9.1.2.7.1.8 Provisions for continuing education of staff;
 - 9.1.2.7.1.9 Provisions for regularly scheduled clinical supervision to teach and enhance the clinical skills of staff;
 - 9.1.2.7.1.10 Individual face-to-face sessions between the team leader and staff to review cases, assess performance and give feedback;
- 9.1.2.8 Maintenance and access to personnel files which shall contain employees' applications, credentials (e.g., copy of current license(s))

and/or certification(s)), job descriptions, and performance appraisals, job titles, training, orientation, salary, staff statement of confidentiality.

- 9.1.2.9 Annual validation of credentials;
- 9.1.2.10 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;
- 9.1.2.11 Work hours including hours of program operation, shifts and overtime compensation.
- 9.1.2.12 Agency policies regarding compensation including:
 - 9.1.2.12.1 Salary ranges, salary increases, and payroll procedures;
 - 9.1.2.12.2 Use of personal automobile for program activities;
 - 9.1.2.12.3 Reimbursement for work related expenses;
 - 9.1.2.12.4 Description of employee benefits.

10 Hours of Operation and Staff Coverage

- 10.1 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:
 - 10.1.1 Every team should have posted standard business hours of operation, to include:
 - 10.1.2 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 beneficiaries served.
 - 10.1.3 Regularly scheduling ACT staff on-call duty to provide crisis services outside of regularly scheduled service provision operations, which shall include responding in-person to a crisis or emergency situation.
 - 10.1.4 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 beneficiaries by phone or by in-person visit to beneficiaries who need face-to-face contact.

- 10.1.5 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.
- 10.1.6 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 beneficiaries for whom this is necessary;
- 10.1.7 The ACT teams shall provide beneficiaries served and, as applicable and with consent of the beneficiary, significant others with information about how to access staff in the event of an emergency including:
 - 10.1.7.1 Rotating coverage 24/7, to be available for face-to-face contacts;
 - 10.1.7.2 Responding to calls from Crisis Intervention to the on-call team member when a face-to-face contact with the beneficiary is needed.

11 Place of Treatment

- 11.1 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.

12 Staff Communication and Planning

- 12.1 The ACT team – Shall conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader or the psychiatric prescriber. These meetings may be conducted in accordance with the following procedures:
 - 12.1.1 The ACT team shall maintain a written or computerized daily log. The daily log provides:
 - 12.1.1.1 A roster of the beneficiaries served in the program, and for each beneficiary:

- 12.1.1.1.1 A brief description of any treatment or service contacts that have occurred during the last twenty-four (24) hours;
- 12.1.1.1.2 A concise, behavioral description of the beneficiary's status that day.
- 12.1.2 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 beneficiaries.
- 12.1.3 The ACT team, under the direction of the team leader, shall maintain a weekly contact schedule for each beneficiary. 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 beneficiary's person-directed treatment plan.
 - 12.1.3.1 The team will maintain a central file of all weekly individual schedules.
 - 12.1.3.2 All weekly individual schedules shall be made available to DSAMH upon request.
- 12.1.4 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.
 - 12.1.4.1 The daily staff assignment schedule shall be made available to DSAMH upon request.
- 12.1.5 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.

- 12.1.6 During the daily organizational staff meeting, the ACT team shall also work with the beneficiary to revise PDRPs as needed, anticipate emergency and crisis situations, and adjust service contacts on the daily staff assignment schedule per the revised treatment plans.
- 12.2 The ACT team shall conduct PDRP planning meetings under the supervision of the team leader and the psychiatric prescriber. These treatment planning meetings shall:
- 12.2.1 Convene at regularly scheduled times per a written or computerized schedule maintained by the team leader.
 - 12.2.2 Occur and be scheduled when the beneficiary 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 beneficiary's family and/or natural supports, other professional supports, if available and at the request of the beneficiary, and require individual staff members to be present and systematically review and integrate beneficiary information into a holistic analysis and work with the beneficiary and team to establish priorities for services.
 - 12.2.3 Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each beneficiary, his/her goals and aspirations, and for each beneficiary to become familiar with all team staff;
 - 12.2.3.1 To participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues;
 - 12.2.3.2 To problem-solve treatment strategies and rehabilitation options;
 - 12.2.3.3 To participate with the beneficiary and the team in the development and the revision of the strengths based, person directed recovery plan;
 - 12.2.3.4 To fully understand the recovery plan rationale in order to carry out the plan with each beneficiary; and
 - 12.2.3.4.1 Updated, when significant clinical changes occur, and/or at the request of the beneficiary, 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.
 - 12.2.3.4.2 Signed and dated by the beneficiary, psychiatric prescriber, team leader, primary care manager(s), and

other natural supports, peer, or professional supports when necessary.

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

13 Staff Supervision

- 13.1 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 policy for supervision and direction shall consist of:
- 13.1.1 Participation with team members in daily organizational staff meetings and regularly scheduled recovery planning meetings to provide staff direction regarding individual cases;
 - 13.1.2 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;
 - 13.1.3 Monthly, formal, and documented supervisory meetings with individual staff members to review their work with beneficiaries, assess clinical performance, and give feedback;
 - 13.1.4 Regular documented reviews, critiques, and feedback of staff documentation (e.g. progress notes, assessments, recovery plans, recovery plan updates); and,
 - 13.1.5 Written documentation of all monthly clinical supervision provided to team staff shall be completed and maintained by the Team Leader.
 - 13.1.5.1 Written documentation shall be signed and dated by the team leader at the time of the supervision session.

14 Evaluation & Assessment

- 14.1 Initial Assessment – Admission to the program commences with the initial evaluation of: 1) the beneficiary’s mental and functional status; 2) any substance use issues; 3)

the effectiveness of past PDRPs;) the current treatment, rehabilitation and support service needs, and 5) 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 PDRP, detailing the beneficiary's goals. The initial PDRP and crisis plan are created with twenty-four (24) hours of the admission to ACT by the team leader or designated team members. Note that the beneficiary is formally admitted as of the date of the initial assessment.

- 14.2 Initial Psychiatric Evaluation – First meeting between the client and the prescriber, to confirm diagnoses, begin medication management, and to form the basis of the Comprehensive Assessment.
- 14.3 Comprehensive Assessment – A complete biopsychosocial (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 beneficiary within thirty (30) days after a beneficiary's admission according to the following requirements and findings presented at the first recovery planning meeting:
 - 14.3.1 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 diagnosis).
 - 14.3.2 Education and Employment: Included in this area is the assessment of community inclusion and integration as it relates to education and employment.
 - 14.3.2.1 Vocational and educational functioning.
 - 14.3.3 Social Development and Functioning: Included in this area is the assessment of the beneficiary'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.
 - 14.3.4 Instrumental Activities of Daily Living (IADL): Included in this area is an assessment of the beneficiary's abilities and barriers in meeting day-to-day activities for independence. This assessment includes, but is not limited to:
 - 14.3.4.1.1 Budgeting and money management;
 - 14.3.4.1.1.1 Financial status, including eligibility/access to entitlements;
 - 14.3.4.1.2 Shopping for groceries and other personal needs;

- 14.3.4.1.3 Housekeeping;
 - 14.3.4.1.4 Conditions of Living:
 - 14.3.4.1.4.1 Adequate housing, with housing checklist completed monthly and made available to DSAMH upon request;
 - 14.3.4.1.5 Personal care (bathing, grooming etc.);
 - 14.3.4.1.6 Laundry;
 - 14.3.4.1.7 Other activities required for independent living.
- 14.3.5 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 beneficiary’s care, and plans to include the family, friends and other supports in treatment moving forward.
- 14.3.6 Strengths and Resources – Members of the ACT team are responsible for engaging the beneficiary in his or her own treatment planning in order to identify individual strengths and resources, as well as those within the beneficiary’s family, natural support network, service system, and community at large. These may include:
- 15.2.6.1.1 Personal skills and talents;
 - 15.2.6.1.2 Personal virtues and traits;
 - 15.2.6.1.3 Interpersonal skills;
 - 15.2.6.1.4 Interpersonal and environmental resources;
 - 15.2.6.1.5 Cultural knowledge;
 - 15.2.6.1.6 Knowledge gained from struggling with adversity;
 - 15.2.6.1.7 Knowledge gained from occupational and parental roles;
 - 15.2.6.1.8 Spirituality and faith;
 - 15.2.6.1.9 Hopes and dreams; and
 - 15.2.6.1.10 Goals and aspirations.
- 14.3.7 While the assessment process shall involve the input of most, if not all, team members, the beneficiary's psychiatric prescriber and/or team leader will assure completion of the written narrative.
- 14.3.8 The Comprehensive Assessment shall be signed and dated by:
- 14.3.8.1 The primary case manager completing the evaluation;
 - 14.3.8.2 The psychiatric prescriber; and

14.3.8.3 The team leader.

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

14.4.1 Assess the beneficiary's readiness for transition to less intensive services, through consideration of the score on the DSAMH-approved ACT Transition Readiness Scale, and in coordination with the PROMISE Care Manager;

14.4.2 Review the progress achieved in accordance to the outcome-oriented plan, and review what is required in order to continue working toward a less intensive level of care;

14.4.3 Ensure a gradual, individualized process which includes continuity of care and preservation of consumer preferences while transitioning to less intensive services.

15 Physical Examination and Follow Up Medical Care

15.1 Beneficiaries 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.

15.1.1 Results of the current physical examination shall be documented in the individual record.

15.1.2 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.

15.1.3 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 beneficiary for possible inclusion in the beneficiary's PDRP and will be documented in the individual record.

15.1.4 The primary prescriber shall act as the attending of record, holistically acknowledging all aspects of the beneficiary's health and wellness and providing guidance to the team.

15.2 The ACT teams will assist beneficiaries in maintaining optimal physical health or will demonstrate efforts to function as a Health Home to beneficiaries by assisting with:

- 15.2.1 Scheduling annual physicals, including lab work and testing, as determined necessary by the physician/prescriber;
- 15.2.2 Making medical appointments;
- 15.2.3 Transportation to medical appointments when the beneficiary:
 - 15.2.3.1 Is unable to independently attend appointments;
 - 15.2.3.2 Is unable to understand the advice of their medical doctor and is need of an advocate for medical care.
- 15.2.4 Developing goals and objectives to address medical care in the beneficiary's PDRP.

16 Person-Directed Recovery Planning

- 16.1 PDRPs will be developed through the following planning process:
 - 16.1.1 The PDRP shall be developed in collaboration with the primary care manager, the beneficiary and:
 - 16.1.1.1 His/her preferred natural supports;
 - 16.1.1.2 Guardian, if any, when feasible and appropriate;
 - 16.1.1.3 Treatment goals provided by the PROMISE Care Manager;
 - 16.1.1.4 Other identified Team members, as indicated (e.g. Vocational Specialist, Chemical Dependency Specialist.)
- 16.2 The beneficiary's participation in the development of the PDRP shall be documented, and the ACT team shall coordinate with the beneficiary to:
 - 16.2.1 identify individual strengths and abilities;
 - 16.2.2 identify individual service needs;
 - 16.2.3 for each service need, set specific and measurable long- and short-term goals;
 - 16.2.4 establish the specific approaches and interventions necessary for the beneficiary to meet his/her goals,
 - 16.2.5 improve his/her capacity to function as independently as possible in the community;
 - 16.2.6 seek to achieve the maximum level of recovery possible as defined by the beneficiary (e.g. a meaningful, satisfying, and productive life); and
 - 16.2.7 Identify interventions that have been helpful or that pose particular risks to the beneficiary.
- 16.3 ACT team staff shall meet at regularly scheduled times for PDRP meetings. The Team Leader shall conduct the PDRP meetings.

- 16.4 ACT staff shall document every effort to ensure that the beneficiary and his/her family and/or natural supports (if desired by the individual) attend the PDRP meeting.
- 16.5 ACT staff shall invite other natural, peer, and/or professional supports (if desired by the beneficiary) to attend in the treatment planning process (e.g. methadone or other SUD treatment program(s), probation and parole, housing support programs, etc.).
- 16.6 ACT staff shall invite the PROMISE Care Manager to attend the PDRP meeting.
- 16.6 Teams are responsible to provide the necessary support to ensure the beneficiary is actively involved in the development of:
 - 16.7.1 Treatment and service goals; and
 - 16.7.2 Participation in the PDRP meetings. This may include:
 - 16.7.2.1 Offering of peer-based coaching and/or;
 - 16.7.2.2 Skills training around his/her role in developing his/her own PDRP.
- 16.8. The PDRP must clearly specify:
 - 16.8.1 The approaches and interventions necessary for the beneficiary to achieve the individual goals;
 - 16.8.1.1 The approaches and interventions that are contraindicated;
 - 16.8.1.2 Who will carry out the approaches and interventions.
 - 16.8.2 The following key areas should be addressed in every beneficiary's PDRP unless they are explored and designated as deferred or referred, with signature by the beneficiary:
 - 16.8.2.1 Psychiatric illness management;
 - 16.8.2.2 Symptom management;
 - 16.8.2.3 Housing;
 - 16.8.2.4 IADLs;
 - 16.8.2.5 Daily structure and employment;
 - 16.8.2.6 Family and social relationships;
 - 16.8.2.7 Physical health;
 - 16.8.2.8 Substance use;
 - 16.8.2.9 Other life areas, goals and aspirations as identified by the beneficiary (e.g., community activities, empowerment, decision-making, educational goals and aspirations, economic improvements etc.)
- 16.9 The beneficiary's own words are reflected in the recovery plan; which may at times include an attached copy of goals written by the beneficiary.
- 16.10 The primary case manager and the team will be responsible for conducting a PDRP update with the beneficiary, any appropriate natural supports, and their PROMISE care manager,

when significant clinical changes occur, and/or at the request of the beneficiary, and/or if 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. As a result of this process, the treatment goals and PDRP are rewritten or otherwise updated if needed.

16.10.1 Any PDRP update developed without the beneficiary's collaboration shall include on-going documented attempts to re-engage the beneficiary in an update.

16.11 The Team Leader will review, sign, and date each PDRP, and will document a brief summary indicating:

16.11.1 Reasons for the update (regular review date or described change in circumstance);

16.11.2 Evaluation of his/her progress/goal attainment;

16.11.3 Evaluation of effectiveness of the interventions;

16.11.4 Satisfaction with services since the last recovery plan.

16.12 The updated PDRP will be signed and dated by:

16.12.1 The beneficiary;

16.12.2 The primary case manager;

16.12.3 The team leader; and

16.12.4 The psychiatric prescriber.

16.13 A copy of the signed PDRP is given to the beneficiary.

17 Core ACT Services

17.1 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.

17.2 Services shall include the following, at a minimum:

17.2.1 Service coordination: Each beneficiary will be assigned a primary case manager who coordinates and monitors the activities of the beneficiary's team. The responsibilities of the primary case manager are:

17.2.1.1 To work with the beneficiary to write the PDRP;

17.2.1.2 To provide individual supportive counseling (more intensive therapy should be provided by Master's level clinicians);

17.2.1.3 To offer options and choices in the recovery plan;

- 17.2.1.4 To ensure that immediate changes are made as the beneficiary's needs change;
- 17.2.1.5 To advocate for the beneficiary's wishes, rights, and preferences;
- 17.2.1.6 To act as principal contact and educator;
 - 17.2.1.6.1 Members of the team share these tasks with the primary case manager and are responsible to perform the tasks when the primary case manager is not working.
- 17.2.1.7 To provide community liaison (Service coordination also includes coordination with community resources, including individual self-help and advocacy organizations that promote recovery.);
- 17.2.1.8 To incorporate and demonstrate basic recovery values in the coordination of services;
- 17.2.1.9 To help ensure the beneficiary will have ownership of his or her own treatment and will be expected to:
 - 17.2.1.9.1 Take the primary role in PDRP development;
 - 17.2.1.9.2 Play an active role in treatment decision making;
 - 17.2.1.9.3 Be allowed to take risks;
 - 17.2.1.9.4 Make mistakes and learn from those mistakes.

17.3 Crisis Assessment and Intervention

- 17.3.1 Crisis assessment and intervention shall be provided 24 hours per day, seven days per week. These services will include telephone and face-to-face contact.
- 17.3.2 A representative from the ACT team will be physically present to support the ACT beneficiary when external crisis responders are involved. When a beneficiary is assigned to ACT, Crisis Intervention is not the primary responder, though may be able to provide assistance, when appropriate.
- 17.3.3 Each ACT beneficiary will have an individualized, strengths-based crisis plan that shall be updated at each PDRP update, or more frequently, as needed.
- 17.3.4 The beneficiary will take the lead role in developing the crisis plan.

17.4 Symptom Management and Psychotherapy – Symptom Management and Psychotherapy shall include, but not be limited to, the following:

- 17.4.1 Psychoeducation regarding:
 - 17.4.1.1 Mental illness;
 - 17.4.1.2 Substance use and co-occurring disorders, when relevant;

- 17.4.1.3 The effects of personal trauma history on mental health and recovery;
and,
- 17.4.1.4 The effects and side effects of prescribed medications, when
appropriate.
- 17.4.2 Symptom management efforts directed to help each individual
identify/target the symptoms and occurrence patterns of his or her mental
illness.
- 17.4.3 Development of methods (internal, behavioral, or adaptive) to help lessen
the effects.
- 17.4.4 Therapy/counseling, including:
 - 17.4.4.1 Individual supportive counseling;
 - 17.4.4.2 Empirically-supported psychotherapy interventions that address
specific symptoms and behaviors (performed by Master's level
clinicians and in accordance with the PDRP);
 - 17.4.4.3 Family therapy, when indicated by the BPS or PDRP; and,
 - 17.4.4.4 Development of an informal support system.
- 17.4.5 Psychological support to beneficiaries, 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 assist with their recovery.
- 17.5 Wellness Management and Recovery Services – Wellness Management and Recovery
Services shall include, but not be limited to, the following:
 - 17.5.1 Defining and identifying the beneficiary's recovery goals within the
beneficiary's frame of reference.
 - 17.5.2 Developing strategies for implementing and maintaining the identified
recovery goals as informed by the beneficiary's strengths.
 - 17.5.3 Psychoeducation and providing the beneficiary with practical information
about mental illness and the beneficiary's diagnoses and experiences with
mental illness.
 - 17.5.4 Training in beneficiary's legal, civil, and human rights, including rights under
the ADA and Olmstead, as well as how to access assistance in achieving
these rights.
 - 17.5.5 Skills training and practice, to include:
 - 17.5.5.1 Developing social supports;
 - 17.5.5.2 Understanding and implementing individual coping skills to decrease
stress;

- 17.5.5.3 Effectively using medication;
- 17.5.5.4 Developing a personal definition of relapse;
- 17.5.5.5 Identifying triggers for relapse and,
 - 17.5.5.5.1 rating strategies for reducing relapse frequency and severity;
 - 17.5.5.5.2 Identifying personal stressors and coping positively with those stressors;
 - 17.5.5.5.3 Identifying and coping with symptoms;
 - 17.5.5.5.4 Getting beneficiary needs met within the mental health system, including empowerment and self-advocacy;
 - 17.5.5.5.6 Learning and practicing new skills as they are developed, with direct assistance.

18 Medication Prescription, Administration, Monitoring and Documentation

- 18.1 The ACT team's psychiatric prescriber shall:
 - 18.1.1 Establish a direct and personal clinical relationship with each beneficiary;
 - 18.1.2 Assess each beneficiary's mental illness symptoms and provide verbal and written information about mental illness;
 - 18.1.3 Review clinical information with the beneficiary, and as appropriate, with the beneficiary's family members or significant others;
 - 18.1.4 Make an accurate diagnosis based on direct observation, available collateral information from the family and significant others, and a current comprehensive assessment, and reevaluate annually or as information warrants;
 - 18.1.5 Provide a diagnostic work-up that will dictate an evidence-based medication pathway that the psychiatric prescriber will follow;
 - 18.1.6 Provide to the beneficiary and, as appropriate, the beneficiary's family and/or significant others, practical education about medication, including:
 - 18.1.6.1.1 Benefits and Risks of various medication strategies.
 - 18.1.7 Consider the preferences of the beneficiary with regard to medications that are incorporated in the beneficiary's service plan;
 - 18.1.8 Devise a medication regimen that will help promote the beneficiary's engagement and ability to self-manage medications;

- 18.1.9 Obtain informed consent from the beneficiary for all medications prescribed;
 - 18.1.10 In collaboration with the beneficiary, assess, discuss, and document the beneficiary's mental illness symptoms and behavior in response to medication and monitor and document any medication side effects;
 - 18.1.11 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.
- 18.2 All ACT team members shall assess and document the beneficiary's behavior and response to medication and shall monitor for medication side effects.
- 18.2.1 Observations will be reviewed with the beneficiary.
- 18.3 The ACT team program shall establish medication policies and procedures which identify processes to:
- 18.3.1 Record physician orders;
 - 18.3.2 Order medication;
 - 18.3.3 Arrange for all beneficiary medications to be organized by the team and integrated into beneficiaries' weekly schedules and daily staff assignment schedules;
 - 18.3.4 Provide security for medications (e.g., long-term injectable, daily, and longer term);
 - 18.3.5 Set aside a private, designated area for set up of medications by the team's nursing staff;
 - 18.3.6 Administer medications per Delaware Board of Nursing LLAM protocols;
 - 18.3.8 Ensure that all beneficiaries have current Medicaid, Medicare, or other insurance to cover medication costs; and
 - 18.3.7 Apply for Patient Assistance Plan (PAP) for all beneficiaries eligible for assistance.

19 Co-Occurring Disorders Services

- 19.1 ACT beneficiaries with a positive screen for co-occurring substance use disorder shall receive an integrated mental health/substance use assessment during the first fourteen (14) days of treatment. The assessment will include:
- 19.1.1 Substance use history;
 - 19.1.2 Trauma history;

- 19.1.3 Parental and familial substance use summary;
- 19.1.4 Effects/impact of substance use;
- 19.1.5 Functional assessment: role played by substances in the beneficiary's life;
- 19.1.6 Factors that have contributed to past successes and relapses;
- 19.1.7 Beneficiary strengths;
- 19.1.8 Social support network (including both individuals who use substances and people who support recovery);
- 19.1.9 Beneficiary's self-identified goals and aspirations.
- 19.1.10 ACT beneficiaries will receive integrated treatment that is:
 - 19.1.10.1 Non-confrontational;
 - 19.1.10.2 Considers interactions of mental illness and substance abuse; and
 - 19.1.10.3 Results in a PDRP that incorporates goals determined by the beneficiary.

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

- 19.2.1 Individual and group interventions (as directed by the PDRP) in:
 - 19.2.1.1 Developing motivation for decreasing use;
 - 19.2.1.2 Developing skills to minimize use;
 - 19.2.1.3 Recognition of negative consequences of use; and
 - 19.2.1.4 Adoption of an abstinence goal for treatment.
- 19.2.2 Engagement (e.g., empathy, reflective listening).
- 19.2.3 Ongoing assessment (e.g., stage of readiness to change, individually-determined problem identification).
- 19.2.4 Motivational enhancement (e.g., developing discrepancies, psychoeducation).
- 19.2.5 Active treatment (e.g., cognitive skills training, community reinforcement).
- 19.2.6 Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

20 Education Services:

20.1 Supported Education – Supported education services are for ACT beneficiaries whose high school, college or vocational education could not start or was interrupted and who wish to include educational goals in their recovery plan. These services provide support in:

- 20.1.1.1 Enrolling and participating in educational activities;

- 20.1.1.2 Strengths-based assessments of educational interests, abilities, and history;
- 20.1.1.3 Pre-admission counseling to determine which school and/or type of educational opportunities may be available;
- 20.1.1.4 Referral to GED classes and testing, if indicated;
- 20.1.1.5 Assistance with completion of applications and financial aid forms;
- 20.1.1.6 Help with registration;
- 20.1.1.7 Orientation to campus buildings and school services;
- 20.1.1.8 Early identification and intervention with academic difficulties;
- 20.1.1.9 Linking with academic supports such as tutoring and learning resources;
- 20.1.1.10 Assistance with time management and schoolwork deadlines;
- 20.1.1.11 Supportive counseling;
- 20.1.1.12 Information regarding disclosing mental illness;
- 20.1.1.13 Advocating with faculty for reasonable accommodations.

21 Vocational Services:

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

21.1.1 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;

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

21.1.2.1 Help and hinder the beneficiary's work performance; and

21.1.2.2 Development of interventions to reduce or eliminate any hindering behaviors and find effective job accommodations.

21.1.2.3 Job development activities;

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

21.1.2.4 Provision of on-the-job or work-related crisis intervention services;

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

22 Instrumental Activities of Daily Living Services (IADLs)

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

- 22.1.1 Individualized assessment;
- 22.1.2 Problem Solving;
- 22.1.3 Skills training/practice;
- 22.1.4 Sufficient side-by-side assistance and support;
- 22.1.5 Modeling;
- 22.1.6 Ongoing supervision (e.g. prompts, assignments, monitoring, encouragement);
- 22.1.7 Environmental adaptations to assist beneficiaries to gain or use the skills required to:
 - 22.1.7.1 Find housing (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating;) which is:
 - 22.1.7.1.1 safe;
 - 22.1.7.1.2 good quality,
 - 22.1.7.1.3 comfortable to the client;
 - 22.1.7.1.4 affordable, and
 - 22.1.7.1.5 clean and habitable (as documented in monthly housing checklist); and,
 - 22.1.7.1.6 In compliance with the Americans with Disabilities Act including the Olmstead Decision (28 C.F.R. § 35.130).
 - 22.1.7.2 Procure necessities (such as telephones, furnishings, linens);
 - 22.1.7.3 Perform household activities, including:
 - 22.1.7.3.1 House cleaning;

- 22.1.7.3.2 Cooking;
- 22.1.7.3.3 Grocery shopping; and
- 22.1.7.3.4 Laundry.
- 22.1.7.4 Carry out personal hygiene and grooming tasks, as needed;
- 22.1.7.5 Develop or improve money-management skills with the goal of attaining independence in management of one's finances;
- 22.1.7.6 Use available transportation; and
- 23.1.7.7 Have and effectively use a personal physician and dentist.

23 Social and Community Integration Skills Training

23.1 Social and community integration skills training serves to support social/interpersonal relationships and leisure-time skills training and includes:

23.1.1 Supportive individual therapy (e.g., problem solving, role-playing, modeling, and support);

23.1.2 Social skills teaching and assertiveness training;

23.1.3 Planning, structuring, and prompting of social and leisure-time activities;

23.1.4 Side-by-side support and coaching;

23.1.5 Organizing individual and group social and recreational activities to structure beneficiaries' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

23.1.5.1 Improve communication skills;

23.1.5.2 Develop assertiveness, and increase self-esteem, as indicated;

23.1.5.3 Increase social experiences;

23.1.5.4 Encourage development of meaningful personal relationships;

23.1.5.5 Plan productive use of leisure time;

23.1.5.6 Relate to landlords, neighbors, and others effectively;

23.1.5.7 Familiarize themselves with available social and recreational opportunities; and

23.1.5.8 Enhance relationships with natural support systems.

23.2 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:

- 23.2.1 Directly assisting beneficiaries in locating housing of their choice, using a variety of housing options, including integrated, community-based, independent housing;
- 23.2.2 Assistance in finding affordable, safe, and decent housing, which affords the beneficiary rights of tenancy, whenever possible;
- 23.2.3 Assisting beneficiaries in maintaining housing by addressing any barriers to same.

24 Certified Peer Recovery Support Services

- 24.1 These include services to validate beneficiaries' experiences and to guide and encourage beneficiaries to take responsibility for, and actively participate in their own recovery, as well as services to help beneficiaries identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce beneficiaries' self-imposed stigma. CPRS services include:
 - 24.1.1 Coaching in the development of empirically-supported peer-based recovery approaches, such as Wellness Recovery Action Plan (WRAP), Whole Health Action Management (WHAM) and Health and Recovery Peer Program (HARP);
 - 24.1.2 Peer counseling and support services, including those which:
 - 24.1.2.1 Promote self-determination; and
 - 24.1.2.2 Encourage and reinforce choice and decision making.
 - 24.1.3 Introduction and referral to individual self-help programs and advocacy organizations that promote recovery.
 - 24.1.4 Assist beneficiaries in self-advocacy and self-directed treatment planning.
- 24.2 The CPRS Specialist will serve as a full team member to support a culture of recovery in which each beneficiary's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, support, and community activities.
- 24.3 Peer staff shall not routinely provide medication education, assistance with medication, or be relegated to a position as a primary provider of transportation.
 - 24.3.1 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 PDRP and obtain permission from DSAMH prior to putting this practice in place;

24.3.1.1.1 The request to 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.

25 Psychoeducation and Support of the Family/Chosen Family

25.1 Services provided or coordinated to beneficiaries' families and other major supports, with individual agreement or consent, include:

25.1.1 Individualized psychoeducation about the beneficiary's illness and the role of the family and other significant people in the therapeutic process;

25.1.2 Family intervention to restore contact, resolve conflict, and maintain relationships with family and/or other significant people;

25.1.3 Ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family/significant others;

25.1.4 Introduction and referral to family self-help programs and advocacy organizations that promote recovery;

25.1.5 Assistance to beneficiaries with their children, including supportive counseling, parenting training, and service coordination, but not limited to:

25.1.5.1 Services to help beneficiaries throughout pregnancy and the birth of a child;

25.1.5.2 Services to fulfill parenting responsibilities and coordinating services for the child;

25.1.5.3 Services to restore relationships with children who are not in the beneficiary's custody.

26 Documentation of Services

26.1 The ACT team will document all services provided to the beneficiary and family in the beneficiary file.

26.1.1 Documentation of each contact/service provided to the beneficiary shall be entered into the beneficiary chart, shall be in accordance with best practices, and include:

- 26.1.1.1 A minimum of three (3) face-to-face contacts per week with an average of two hours of service/week or more, based on the PDRP and medical necessity;
 - 26.1.1.2 Services provided and the beneficiary's response to those services;
 - 26.1.1.3 Progress in meeting recovery plan goals;
 - 26.1.1.4 Coordination and Communication related to beneficiary's care, to include:
 - 26.1.1.4.1 Hospitalization admissions and discharges;
 - 26.1.1.4.2 Other medical providers.
 - 26.1.1.5 Changes in recovery plan goals;
 - 26.1.1.6 Plans for continuation of care; and,
 - 26.1.1.7 The signature of the person entering the note and the date entered into the beneficiary chart.
- 26.1.2 If a less intense level of service is provided to an beneficiary over the course of a 90-day period due to the person's recovery progress, the ACT team will document this and discuss with the PROMISE Care Manager whether the beneficiary can transition to a lower level of care. The ACT Transition Readiness Scale can be used to document whether this change is indicated. If so, the ACT team and PROMISE can assist the beneficiary in making the transition to a lower level of care.
- 26.1.3 If a less intense level of service is provided to a beneficiary over the course of a 90 day period, due to lack of engagement, the PDRP should document efforts to reengage the beneficiary in services, or document a plan to discharge.

27 Facility Standards

- 27.1 The facility(s) within which the ACT team(s) operate shall meet the following criteria:
- 27.1.1 They shall post a Certificate of Occupancy;
 - 27.1.2 They shall meet all applicable fire and life safety codes;
 - 27.1.3 They shall be maintained in a clean and safe condition;
 - 27.1.4 They shall provide rest rooms maintained in a clean and safe condition available to beneficiaries, visitors, and staff;
 - 27.1.5 They shall be accessible to the beneficiary served;
 - 27.1.6 They shall provide a smoke free environment.

28 Individual Rights and Grievance Procedures

28.1 ACT teams shall be knowledgeable about and familiar with beneficiary rights, including the clients' rights to:

28.1.1 Confidentiality;

28.1.2 Informed consent to medication and treatment;

28.1.3 Treatment with respect and dignity;

28.1.4 Prompt, adequate, and appropriate treatment;

28.1.5 Treatment which is under the least restrictive conditions and which promotes beneficiaries' meaningful community integration and opportunities to live like ordinary Delawareans;

28.1.6 Nondiscrimination;

28.1.7 Control of own money;

28.1.8 Voice or file grievances or complaints.

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

28.2.1 Grievance or complaint procedures under:

28.2.1.1 Medicaid;

28.2.1.2 DSAMH;

28.2.1.3 Americans with Disabilities Act;

28.2.1.4 Delaware Human Rights Commission and U.S. Department of Justice (Human Rights);

28.2.1.5 U.S. Department of Housing and Urban Development;

28.2.1.6 PROMISE Manual.

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

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

28.3.1.1 The names and phone numbers of beneficiaries who can receive grievances, both at the agency and with other organizations in §30.2 of these standards;

28.3.1.2 A standardized process for accepting and investigating grievances;

28.3.1.3 Maintain documentation of the investigation and resolution of all grievances; and,

28.3.1.4 Provide for its availability to DSAMH upon request.

- 28.4 ACT teams should ensure that all beneficiaries receive 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.
- 28.5 ACT teams will also ensure that beneficiaries receive services in their chosen language when their primary language is not English. Teams will arrange for interpreter services, as required by federal law.

29 Administrative Standards

29.1 Individual Records:

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

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

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

29.4 Beneficiary 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).

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

29.6 The active beneficiary record shall contain the following:

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

29.6.2 An up-to-date face sheet:

29.6.2.1 Date of Admission;

29.6.2.2 Guardian and Contact Information;

29.6.2.3 Emergency Contacts and Information;

29.6.2.4 Allergies;

29.6.2.5 Diagnoses;

29.6.2.6 Family/Natural Supports;

29.6.2.6.1 Contact Information;

- 29.6.2.7 Treating Psychiatrist and Contact Information
- 29.6.2.8 Primary Care Physician and Contact Information;
- 29.6.2.9 Existence of Advanced Directive and/or Psychiatric Advanced Directive;
- 29.6.2.10 Beneficiary's Address and Phone Number;
- 29.6.2.11 Photo of the Beneficiary;
- 29.6.2.12 Date of Birth;
- 29.6.2.13 MCI Number;
- 29.6.2.14 Insurance;
- 29.6.2.15 Race, Ethnicity, Gender.
- 29.6.3 Consent to treatment signed by the beneficiary;
- 29.6.4 Consent to any occasion of release of information;
- 29.6.5 Documentation that the beneficiary has been informed of his/her rights and the beneficiary's level of understanding of these rights;
- 29.6.6 Documentation that the beneficiary has been provided with information regarding the process by which grievances can be addressed;
- 29.6.7 Reports from all examinations, tests, and clinical consults;
- 29.6.8 Hospital discharge summaries;
- 29.6.9 Comprehensive medical psychosocial evaluation;
- 29.6.10 Comprehensive PDRP development and updates/amendments to PDRP with documented evidence of the beneficiary's participation;
- 29.6.11 Crisis intervention plan and updates;
- 29.6.13 Progress notes;
- 29.6.14 Documentation of case review with clinical supervisor;
- 29.6.15 Medication records;
- 29.6.16 Discharge documentation.

30 Performance Improvement Program

30.1 The ACT program 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 the 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:

- 30.1.1 A statement of the program's objectives. The objectives shall relate directly to the program's beneficiaries or target population.

- 30.1.2 Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
- 30.1.3 Methods for documenting achievements related to the program's stated objectives.
- 30.1.4 Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
- 30.1.5 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.
- 30.1.6 The ACT team shall maintain performance improvement and program evaluation policies and procedures that include:
 - 30.1.6.1 a concurrent utilization review process;
 - 30.1.6.2 a retrospective performance improvement review process;
 - 30.1.6.3 a process for clinical care evaluation studies; and
 - 30.1.6.4 a process for self-survey for compliance with the certification standards and fidelity standards as prescribed by the Division.
- 30.2 The ACT team(s) shall ensure that data on the beneficiary'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.
- 30.3 The ACT team(s) shall use the data to develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and beneficiary involvement in designing and implementing culturally-aware activities and services that reflect the population that the program serves.
- 30.4 Certified and/or Certified and Contracted Providers will undergo, in most cases, a simultaneous contract review and certification by Policy and Compliance audit teams.
 - 30.4.1 Additional audit processes may be conducted by DSAMH contracts, fiscal, or Community Behavioral Health Bureau.
 - 30.4.2 If several deficiencies are found during Contract Review, this may affect the length of Certification. Providers are expected to follow the specific scopes, as deemed in the Contract.

30.5 An Administrative Appeal, requesting a formal change to an official decision regarding program certification, when a program is found in provisional status, may be made to the DSAMH Policy and Compliance Chief within five (5) business days after the initial certification has been received.

Appendix A

Target Criteria A: An individual must have formally received one of the included Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses that constitute the targeted portion of the State’s definition of SPMI, or a diagnosis of post-traumatic stress disorder (PTSD) by a qualified clinician. Diagnoses include the following:

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
295.10	295.90	Schizophrenia, Disorganized Type (<i>In DSM 5 Disorganized subtype no longer used</i>)	Psychotic Disorders ²
295.20	295.90	Schizophrenia, Catatonic Type (<i>In DSM 5 Catatonic subtype no longer used</i>)	Psychotic Disorders
295.30	295.90	Schizophrenia, Paranoid Type (<i>In DSM 5 Paranoid subtype no longer used</i>)	Psychotic Disorders
295.40	295.40	Schizophreniform Disorder	Psychotic Disorders
295.60	295.90	Schizophrenia, Residual Type (<i>In DSM 5 Residual subtype no longer used</i>)	Psychotic Disorders
295.70	295.70	Schizoaffective Disorder	Psychotic Disorders
295.90	295.90	Schizophrenia, Undifferentiated Type (<i>In DSM 5 Undifferentiated subtype no longer used</i>)	Psychotic Disorders
296.30	296.30	Major Depressive Disorder, Recurrent, Unspecified	Mood Disorders ³
296.32	296.32	Major Depressive Disorder, Recurrent, Moderate	Mood Disorders
296.33	296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features (<i>In DSM 5, “Without Psychotic Features” is not a further specifier</i>)	Mood Disorders
296.34	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features (<i>In DSM 5, “With psychotic features” is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁴	Mood Disorders

² In DSM 5, the associated diagnostic category is labeled, “Schizophrenia Spectrum and Other Psychotic Disorders”.

³ In DSM 5, mood disorders are broken out into “Depressive Disorders” and “Bipolar and Related Disorders”.

⁴ The DSM 5 code for Major Depressive Disorder, Recurrent, with Psychotic Features is 296.34.

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
296.40	296.40	Bipolar I Disorder, Most Recent Episode Hypomanic ⁵	Mood Disorders
296.42	296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	Mood Disorders
296.43	296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features (<i>In DSM 5, "Without Psychotic Features" is not a further specifier</i>)	Mood Disorders
296.44	296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features (<i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁶	Mood Disorders
296.50	296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	Mood Disorders
296.52	296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	Mood Disorders
296.53	296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/o Psychotic Features (<i>In DSM 5, "Without Psychotic Features" is not a further specified</i>)	Mood Disorders
296.54	296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/ Psychotic Features (<i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁷	Mood Disorders
296.60		Bipolar I Disorder, Most Recent Episode Mixed, Unspecified (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders

⁵ In DSM 5 code 296.40 is also used for "Bipolar I Disorder, Current or Most Recent Episode Manic, Unspecified".

⁶ The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features" is 296.44.

⁷ The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Depressed, with Psychotic Features" is 296.54.

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
296.62		Bipolar I Disorder, Most Recent Episode Mixed, Moderate (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.63		Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.64		Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.70	296.70	Bipolar Disorder, Most Recent Episode Unspecified	Mood Disorders
296.89	296.89	Bipolar II Disorder	Mood Disorders
297.1	297.1	Delusional Disorder	Psychotic Disorders
301.0	301.0	Paranoid Personality Disorder	Personality Disorders
301.20	301.20	Schizoid Personality Disorder	Personality Disorders
301.22	301.22	Schizotypal Personality Disorder	Personality Disorders
301.83	301.83	Borderline Personality Disorder	Personality Disorders
309.81	309.81	Posttraumatic Stress Disorder (PTSD)	Anxiety Disorders ⁸

Target Criteria B: Individuals may also meet other targeted DSM diagnoses. The DSM diagnosis must be among those that are included in the following larger DSM categories (excluding pervasive developmental disorders):

- Mood Disorders:
In DSM 5 “Depressive Disorders” and “Bipolar and Related Disorders” are separated out as diagnostic groupings.
- Anxiety Disorders:
*DSM 5 includes a separate category, “Obsessive-Compulsive and Related Disorders”.
DSM 5 includes a separate category, “Trauma- and Stressor-Related Disorders”.*
- Schizophrenia and Other Psychotic Disorders:
In DSM 5 this category is labeled, “Schizophrenia Spectrum and Other Psychotic Disorders”.

⁸In DSM 5, PTSD is moved to another diagnostic category, called “Trauma- and Stressor-Related Disorders”.

- Dissociative Disorders
- Personality Disorders
- Substance-Related Disorders:
In DSM 5 this category is labeled, “Substance-Related and Addictive Disorders”.

Functioning Criteria

Each person who is screened and thought to be eligible for PROMISE must receive the State required diagnostic and functional assessment using the Delaware-specific ASAM tool.

Functional Criteria A: If the individual meets Targeting Criteria A, the individual must be assessed with a rating of moderate on at least one of the six Delaware-specific ASAM dimensions. The six dimensions include the following:

1. Acute intoxication and/or withdrawal potential — substance use.
2. Biomedical conditions/complications.
3. Emotional/behavioral/cognitive conditions or complications (with five sub-dimensions, including suicidality, self-control/impulsivity, dangerousness, self-care, and psychiatric/emotional health).
4. Readiness to change (with two sub-dimensions, including understanding of illness and recovery, and desire to change).
5. Relapse, continued use, continued problem potential.
6. Recovery environment (with two sub-dimensions, including recovery environment and interpersonal/social functioning).

Functional Criteria B: If the individual does not meet Target Criteria A, but does meet Target Criteria B, the individual must be assessed with a rating of severe on at least one of the above six Delaware-specific ASAM dimensions.

Functional Criteria C: An adult who has previously met the above target and functional criteria and needs subsequent medical necessary services for stabilization and maintenance. The individual continues to need at least one HCBS service for stabilization and maintenance (e.g., at least one PROMISE service).