

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

**Assertive Community Treatment
Intensive Care Management**

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

OVERVIEW

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

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

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

1 CERTIFICATION FOR PROVIDER PARTICIPATION

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

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

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

1.2.1.1 Private non–profit human service corporations;

1.2.1.2 Private for–profit human service corporations;

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

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

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

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

1.2.4.2 Documents provided to the Division by the organization;

1.2.4.3 Documented compliance with organizational, program and administrative standards;

1.2.4.4 On–site observations by surveyor.

2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the personal effectiveness and appropriateness of treatment and rehabilitative services available to them.

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

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

ICM (Intensive Care Management) Team is a group of ten (10) ICM staff members who together have a range of clinical and rehabilitation skills and expertise. The ICM team members are assigned by the team leader and the psychiatric prescriber to work collaboratively with an individual and his/her family and/or natural supports in the community by the time of the first individual assessment and subsequent person directed recovery planning meeting. The ICM team serves up to 200 individuals and thus has a maximum staff to client ration of 1:20.

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

Instrumental Activities of Daily Living (IADL) include approaches to support individuals and build skills in a range of activities of daily living, including but not limited to finding housing, performing household activities, increased independence in carrying out personal hygiene and

grooming tasks, money management, accessing and using transportation resources, and accessing services from a physician and dentist.

LGBTQ and 2SP individuals are members of the lesbian, gay, bisexual, transgendered, queer or queer-identified communities and sexual minorities of tribal nations that identify as two spirited persons.

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

Medication Adherence Education involves the sharing of information from the ACT or ICM team members to the individual or the individual's natural supports about pros and cons of taking medication for mental health conditions. Peers may assist with medication adherence education when the team determines that the Peer will have the most success in helping the individual served understand the pros and cons of medication interventions and their choices around whether or not a medication regime will enhance the individual's recovery.

Medication Assistance is the oversight of medication adherence where a member of the ACT or ICM team observes or provides training in self-administration of medication. With the exception of a registered nurse or psychiatric prescriber, all team members must receive Assistance With Self Administered Medication (AWSAM) training at the beginning of employment and annually thereafter. Team members required to participate in AWSAM training may not observe medication assistance prior to completing initial AWSAM training during orientation and annual training thereafter.

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

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

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

Peer Support and Wellness Recovery Services are services provided by team members who have experience as recipients of mental health services. The role of the peer support includes providing services that serve to validate individuals' experiences, provide guidance and encouragement to individuals to take responsibility for and actively participate in their own recovery, and help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma. The scope of practice for peers includes peer counseling and support, assistance with developing person directed recovery plans, engagement through outreach and support, education on advocacy for the individual person and others, participation in all daily, weekly or monthly team meetings as an inclusive member of the team.

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

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

The primary care manager develops and collaborates with the individual to write the person directed recovery plan, offers options and choices in the recovery plan, ensures that immediate changes are made as the individual's needs change, and advocates for the individual's wishes, rights, and preferences. The primary care manager also works with other community resources,

including individual-run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the individual. The primary care manager provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people. In most cases the primary practitioner is the first team member available to the individual in crisis. The primary care manager shares these service activities with other members of the team who are responsible to perform them when the primary care manager is not working.

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

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

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

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

Recovery Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of the meeting is for the staff, and the individual and his/her family/natural supports (all working as a team) to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment to learn as much as possible about the individual's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each individual and his/her goals and aspirations and for each individual to become familiar with each team member; to participate in the ongoing assessment and

reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; and to fully understand the recovery plan rationale in order to carry out the plan for each goal.

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

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.

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

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

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

Vocational Services include work-related services to help individuals value, find, and maintain meaningful employment in community-based job sites as well as job development, skills training and coordination with employers.

Weekly Individual Contact Schedule is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) that the ICM Team uses to help guide the goals and objectives in an individual's person directed recovery plan. The team shall maintain an up-to-date weekly individual contact schedule for each individual in accordance with the person directed recovery plan.

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

3 Admission and Discharge Criteria

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

3.1.1 Severe and persistent mental illness (SPMI) that seriously impairs an individual's functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals must have a primary mental health diagnosis or co-occurring disorder (COD) 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 or ICM 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 or ICM services may be considered for an ACT or ICM team if an assessment by the team supports ACT or ICM services as the best course of service.

3.1.2 Significant impairments as demonstrated by at least one of the following conditions:

3.1.2.1 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 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 or ICM team.

- 3.1.2.2 Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role, e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities (for ACT or ICM services).
- 3.1.2.3 Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing) (ACT and ICM).
- 3.1.2.4 Continuous high-service needs as demonstrated by at least one of the following:
 - 3.1.2.4.1 High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services (for ACT services).
 - 3.1.2.4.2 Intractable (i.e., persistent or very recurrent) severe major symptoms, e.g., affective, psychotic, suicidal (for ACT services).
 - 3.1.2.4.3 Co-occurring substance use and SPMI or SMI of significant duration, e.g., greater than six months (for ACT or ICM services).
 - 3.1.2.4.4 High risk or recent history of criminal justice involvement, e.g., arrest and incarceration (for ACT or ICM services).
 - 3.1.2.4.5 Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at imminent risk of becoming homeless (for ACT services).
 - 3.1.2.4.6 Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available (for ACT services).
 - 3.1.2.4.7 Difficulty effectively utilizing traditional office-based outpatient services or other less-intensive community-

based programs, e.g., individual fails to progress, drops out of service (for ACT or ICM services).

3.1.3 Documentation of admission shall include:

3.1.3.1 Evidence that one of the criteria in §3.1.4.3 is met;

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

3.1.3.3 The signature of the psychiatric prescriber.

3.1.4 Engagement and enrollment into the ACT or ICM team will begin within five (5) days of referral to the ACT or ICM team.

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

3.2 The termination of services shall occur when an individual:

3.2.1 Has successfully reached individually-established goals for discharge and when the individual and program staff mutually agrees to the termination of services;

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

3.2.3 Demonstrates an ability to function in all major role areas (i.e., work, social, self-care) for at least one year without significant recurrence of illness after services are reduced or withdrawn;

3.2.4 Declines or refuses services and requests discharge, despite the team's documented best efforts to develop a mutually acceptable person directed recovery plan with the individual and to utilize appropriate engagement techniques.

3.2.5 In addition to the discharge criteria listed above based on mutual agreement between the individual, ACT staff, or ICM staff, an individual

discharge may also be facilitated due to any one of the following circumstances:

3.2.5.1 Death.

3.2.5.2 Inability to locate the individual despite documented active outreach efforts by the team for a period of ninety (90) continuous days.

3.2.5.3 Long-term incarceration of ninety (90) days or more.

3.2.5.4 Long-term hospitalization where it has been determined, based on mutual agreement by the hospital treatment team and the ACT or ICM team, that the individual will not be appropriate for discharge from the hospital for a prolonged period of time

3.2.6 If the individual is accessible at the time of discharge, the team shall ensure individual participation in all discharge activities.

3.2.7 The discharge summary shall include:

3.2.7.1 Date of discharge;

3.2.7.2 Reason for discharge;

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

3.2.7.3.1 DSM diagnosis;

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

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

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

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

3.2.7.4 The discharge summary shall be:

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

3.2.7.4.2 Signed and dated by:

3.2.7.4.2.1 The individual when the discharged is planned;

3.2.7.4.2.2 The primary care manager;

3.2.7.4.2.3 The physician;

3.2.7.4.2.4 The Team Leader.

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

4 Service Intensity and Capacity

4.1 Staff-to-Individual Ratio ACT and ICM:

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

4.1.2

4.1.3 Each ICM team shall have the organizational capacity to provide a staff-to-individual ratio of (1) full-time equivalent (FTE) staff person for every twenty (20) individuals served by the team.

4.1.3.1 Distinct ACT and ICM teams are required.

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

4.1.5 The maximum number of individuals being served by any one ICM team is two hundred (200).

4.2 Staff Coverage

4.2.1 Each ACT and ICM 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 have the capacity to provide multiple contacts per week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as three to four times per day, seven days per week and depend on individual need and a mutually agreed upon plan between individuals and program staff. All team members shall share responsibility for addressing the needs of all individuals requiring frequent contact as appropriate.

4.3.2 The ICM team shall have the capacity to provide multiple contacts per month with the capability to refer individuals to an ACT team during periods where the individuals' symptoms make weekly or daily contacts necessary. Contacts should be more frequent as mutually agreed upon between individual and program staff, but no less frequently than once every fourteen (14) days. Many, if not all, staff shall share responsibility for addressing the needs of all individuals requiring more frequent contact.

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

4.3.3.1 Psychiatric and substance abuse treatment;

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

4.3.3.1.2 Chemical Dependency Specialist: Face-to-face evaluation minimally every seven (7) days for the first sixty (60) days after admission and then every fourteen (14) days thereafter when an individual is known to abuse substances and until the individual and team determine that the individual's dependency on substances is in remission.

4.3.3.2 Medication monitoring as follows:

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

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

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

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

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

4.3.3.2.4.2 Dosage;

- 4.3.3.2.4.3 Route of administration;
- 4.3.3.2.4.4 Frequency of administration;
- 4.3.3.2.4.5 Signature of the physician prescribing the medication;
- 4.3.3.2.4.6 All known drug allergies.

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

4.3.3.2.5.1 Medication administration records shall contain the following:

- 4.3.3.2.5.1.1 Name of the medication (including brand or generic, if specified);
- 4.3.3.2.5.1.2 Dosage;
- 4.3.3.2.5.1.3 Route of administration;
- 4.3.3.2.5.1.4 Frequency of administration;
- 4.3.3.2.5.1.5 All known drug allergies;
- 4.3.3.2.5.1.6 Name of the person administering or assisting with the administration of medication.
- 4.3.3.2.5.1.7 Signature of the person administering or assisting with the administration of medication.

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

- 4.3.3.2.5.2.1 Laboratory studies for all medications which require laboratory monitoring as recommended in the current Physician's Desk Reference;
 - 4.3.3.2.5.2.1.1 Laboratory reports shall:
 - 4.3.3.2.5.2.1.1.1 be reviewed and signed by the psychiatric prescriber or Registered Nurse within two (2) days of receipt.
 - 4.3.3.2.5.2.2 Results of all laboratory studies shall be documented in the individual's chart within 30 days.
 - 4.3.3.2.5.2.3 For persons receiving anti-psychotic medication:
 - 4.3.3.2.5.2.3.1 , the AIMS (Abnormal Involuntary Movement Scale) shall be performed no less than annually to assess individuals at risk for developing Tardive Dyskinesia.
 - 4.3.3.2.5.2.3.2 Annual screening for metabolic disorders in individuals

prescribed atypical antipsychotic medications.

4.3.3.2.5.2.4 Education of individuals regarding side effects of prescribed psychotropic medications and strategies for assuming responsibility for self-medication.

4.3.3.2.6 Monitoring of vital signs to include temperature, blood pressure, pulse, respiration, weight and BMI no less than monthly.

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

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

5 Staff Requirements

5.1 Qualifications

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

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

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

6 ACT Team Size and Composition

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

6.2 Mental Health Professionals on Staff

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

6.2.1.1 Mental health professionals are individuals with:

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

6.2.1.1.1.1 Psychiatric medicine;

6.2.1.1.1.2 Nursing;

6.2.1.1.1.3 Social work

6.2.1.1.1.4 Rehabilitation counseling;

6.2.1.1.1.5 Psychology;

6.2.1.1.1.6 Mental health counseling.

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

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

6.2.2 Mental health professionals operate under the code of ethics of their professions.

6.2.3 Required among the mental health professionals are:

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

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

7 ACT Required Staff

7.1 The chart below shows the required staff:

Position	Requirements
Team leader	1 FTE (Master's level)
Psychiatric prescriber	1 /FTE for 80–100 Individuals
Registered Nurse	2–3 FTE (A minimum of one RN must be at the Bachelor's level)
Peer Specialist	1 FTE
Master's level*	2 FTE (Including one the Team Leader)
Bachelor's Level*	2 FTE Including Housing Specialist
Program/Administrative Assistant	1 FTE
*Chemical Dependency Specialist (CADC or national equivalent)	1 FTE (Can be one of the Master's or Bachelor's level team members)

7.2 Chemical Dependency Specialists may be included within either the Master's level or Bachelor's staffing categories as outlined in §6.2.3 of these standards.

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

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

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

7.3.2.1 A person with a Medical Degree or Doctor of Osteopathy degree, licensed to practice medicine in Delaware and who has completed (or

is enrolled in) an accredited residency training program in psychiatry, internal medicine or family practice.

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

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

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

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

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

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

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

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

7.3.6 **Peer Specialist:** A minimum of one (1) FTE peer specialist is required on an ACT team. Because of his/her life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly

individualized services in the community and promote individual self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

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

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

7.3.7.2 A paraprofessional mental health worker may have:

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

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

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

8 ICM Required Staff

8.1 The chart below shows the required staff:

Position	Requirements
Team leader	.5–1 FTE (1FTE when the Psychiatric Prescriber is less than a .5 FTE)
Psychiatric Prescriber	.5 FTE (When the Team Leader is 1 FTE, the Psychiatric Prescriber is less than .5)
Registered Nurse	1–1.5 FTE(s)
Peer Specialist	(.5) FTE
Master’s level*	1 FTE
Bachelor’s Level*	1 FTE Including .5/FTE Housing Specialist
Program/Administrative Assistant	1FTE
* Chemical Dependency Specialist (CADC or national equivalent)	.5 FTE (may be a Master’s or Bachelor’s level)

8.2 Chemical Dependency Specialist may be included within either the “Master’s level” or “Bachelor’s Level” staffing categories above.

8.3 The following provides a description of and qualifications for required staff on all ICM teams:

8.3.1 **Team Leader:** A half-time (.5) (when there is a full time FTE psychiatric prescriber) or one (1) FTE team leader/supervisor (when the psychiatric prescriber is half-time (.5) who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ICM team. The team leader has a Master’s degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatric prescriber.

8.3.2 **Psychiatric Prescriber** may include:

8.3.2.1 A person with a Medical Degree or Doctor of Osteopathy degree, licensed to practice medicine in Delaware and who has completed (or

is enrolled in) an accredited residency training program in psychiatry, internal medicine or family practice.

8.3.2.2 A licensed nurse practitioner who is licensed in the State of Delaware to diagnosis mental health disorders and to prescribe psychotropic medications for such disorders.

8.3.2.3 The psychiatric prescriber provides clinical services to all ICM individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services. The psychiatric prescriber will be a half-time (.5) FTE when the Team Leader is full time or one (1) FTE when the Team Leader is half-time (.5).

8.3.3 **Registered Nurses:** All registered nurses shall be licensed in the State of Delaware or participating in the Nurse Licensure Compact (NLC). A minimum of one (1) FTE and a maximum of one and one-half (1.5) FTE registered nurses are required.

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

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

8.3.5.1 Certification in the state of Delaware as a Certified Alcohol and Drug Counselor (CADC) or Certified Co-occurring Disorder Counselor (CCDC); OR

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

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

8.3.6 **Vocational Specialist:** One or more team members with training and experience in vocational services shall be designated the role of vocational specialist.

8.3.7 **Peer Specialist:** A minimum of one (1) half-time (.5) peer specialist is required on an ICM team. Because of his/her life experience with mental illness and mental

health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote individual self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

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

8.3.8.1 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 severe and persistent mental illness.

8.3.8.2 A paraprofessional mental health worker may have:

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

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

9 *Policy and Procedure Requirements:*

- 9.1 The ACT or ICM program shall maintain a written Procedure Manual for its staff. A mechanism shall be in place to ensure that the procedures manual is updated periodically as needed but not less frequently than every (2) two years, and that the staff of the program is notified promptly of changes. The manual shall include:
 - 9.1.1 A statement of the program's values and mission including the relationship of these factors to achieving the goals of the ADA and other essential rights of people with psychiatric disabilities, included shall be:
 - 9.1.1.1 Policies and procedures that continually assess the program to assure:
 - 9.1.1.2 A trauma informed and responsive environment;
 - 9.1.1.3 An environment that is culturally sensitive to the populations that the programs services including ethnic/cultural/religious minorities and LGBTQ and 2SP individuals;
 - 9.1.2 Referral policies and procedures that facilitate individual referral;
 - 9.1.3 Detailed procedures for assessment, recovery planning and documentation;
 - 9.1.4 Policies and procedures for medication management in compliance with all applicable rules, regulations and requirements of the Delaware Board of Medical Practice, the Delaware Board of Nursing and the Delaware Board of Pharmacy (if applicable) to include policies and procedures for:
 - 9.1.4.1 Prescribing medication;
 - 9.1.4.2 Storage of medication;
 - 9.1.4.3 Handling of medication;
 - 9.1.4.4 Distribution of medication;
 - 9.1.4.5 Disposing of medication;
 - 9.1.4.6 Recording of medication used by individuals
 - 9.1.4.7 Assistance with medication in accordance with AWSAMH.
 - 9.1.5 Policies and procedures for handling on-call responsibilities and individual emergencies to include:
 - 9.1.5.1 specific program standards for intervention to avert hospitalization,

- criminal justice system involvement, or other harmful outcomes;
- 9.1.6 Policies and procedures for accessing and documenting the need for outside consultation to further the service goals or clinical needs of consumers;
- 9.1.7 Detailed instructions for application to and communication with entitlement authorities including but not limited to:
 - 9.1.7.1 The Social Security Administration;
 - 9.1.7.2 Social Services (SNAP, WIC, general relief, energy assistance, etc.)
 - 9.1.7.3 Medicaid;
 - 9.1.7.4 Medicare;
 - 9.1.7.5 Prescription Assistance Program (PAP)
 - 9.1.7.6 Rep Payee (when applicable)
- 9.1.8 Policies and procedures for obtaining releases to share Protected Health Information about individuals with family members or others;
- 9.1.9 Policies and procedures regarding communicating and handling financial resources of the program;
- 9.1.10 Policies and procedures regarding the coordination of financial activities with the individual's representative payee for payment from the Social Security Administration;
- 9.1.11 Policies and procedures for the receipt, consideration and resolution of individual complaints and/or grievances regarding treatment decisions and practices or other program activities.
- 9.1.12 Policies and procedures for reporting instances of possible abuse or neglect to DHSS/DSAMH, law enforcement, and other entities in accordance with state and federal regulations and laws;
- 9.1.13 Policies and procedures for assisting consumers in securing legal counsel or other special professional expertise when needed;
- 9.1.14 Policies and procedures for ensuring that consumers are not subject to

unwarranted coercion, including legal coercion (outpatient commitment, guardianship);

9.1.15 Policies and procedures to ensure that consumers are afforded an opportunity to execute Advance Directives or medical or legal documents to ensure that their preferences and considered in the event of a crisis or temporary inability to make informed decisions;

9.1.16 References to other policies, procedures, laws or regulations as may be promulgated or required by the federal government, the State of Delaware, the Department of Health and Social Services and its Divisions.

10 Personnel Management

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

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

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

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

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

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

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

10.1.2.1 Verification of credentials and references;

10.1.2.2 Criminal background checks including;

10.1.2.2.1 Registration on Adult Abuse and Child Abuse registries;

10.1.2.3 Policies and procedures for employee performance appraisal including;

10.1.2.4 A code of ethics;

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

10.1.2.6 Conditions and procedures for employee grievances and appeals;

10.1.2.7 An annual staff development plan which shall include:

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

10.1.2.7.1.1 Review of these standards;

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

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

10.1.2.7.1.4 Review of DHSS Policy Memorandum #46;

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

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

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

10.1.2.7.1.8 Provisions for continuing education of staff;

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

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

10.1.2.7.1.10 Individual face-to-face sessions between the team leader and staff to review cases, assess

performance and give feedback;

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

11 Hours of Operation and Staff Coverage

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

11.1.1 Regularly operating and scheduling team members to work two overlapping eight-hour shifts between the hours of 8:30 A.M. and 8:30 P.M. with a minimum of one (1) staff 4:30 P.M. to 8:30 P.M.

11.1.2 Regularly operating and scheduling a minimum of two (2) ACT staff to work one eight-hour shift each weekend day and every holiday. ICM teams will have staff available as needed on weekends and holidays and easily accessible by phone.

11.1.3 Regularly scheduling ACT or ICM staff on-call duty to provide crisis services outside of regularly scheduled service provision operation.

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

11.1.5 Regularly arranging for and providing psychiatric backup during all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the ACT or ICM psychiatric prescriber during all hours is not feasible, alternative psychiatric backup that meets the psychiatric prescriber criteria must be arranged (e.g., community or crisis intervention, mental health center, emergency room psychiatric prescriber).

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

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

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

12 Place of Treatment

- 12.1 Seventy-five (75%) percent of ACT service contacts shall be provided in non-office based or non-facility-based settings. Forty (40%) percent of ICM service contacts shall be provided in non-office based or non-facility-based settings. The program will collect data regarding the percentage of individual contacts in the community as part of its Quality Improvement (QI) Plan and report this data during fidelity reviews.

13 Staff Communication and Planning

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

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

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

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

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

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

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

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

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

13.1.4 The ACT team, under the direction of the team leader, shall develop a *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, job development, recovery planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.

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

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

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

13.2 **The ICM team** shall conduct, at a minimum, weekly organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

13.2.1 The ICM team shall maintain a written or computerized log. The log provides:

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

- 13.2.1.1.1 a brief documentation of any treatment or service contacts that have occurred during the last seven (7) days;
 - 13.2.1.1.2 A concise, behavioral description of the individual's status that week.
- 13.2.2 The ICM weekly organizational staff meeting shall commence with a review of the log to update staff on the treatment contacts that occurred during the preceding seven (7) days and to provide a systematic means for the team to assess the week-to-week progress and status of all individuals.
- 13.2.3 The ICM team, under the direction of the team leader, shall maintain a *weekly individual contact schedule* for each individual served and from the weekly individual contact schedule, prepare:
 - 13.2.3.1 A central file of all individual schedules organized by month.
 - 13.2.3.2 All monthly schedules shall be made available to DSAMH upon request.
- 13.2.4 The ICM team, under the direction of the team leader, shall develop a *monthly staff assignment schedule* from the central file of all monthly individual schedules. The 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, job development, recovery planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that month. The schedule shall be broken into fourteen (14) day rosters and clearly identify the services to be provided by each team member for each day of the week.
 - 13.2.4.1 The monthly staff assignment schedule shall be made available to DSAMH upon request.
- 13.2.5 The monthly organizational staff meeting will include a review by the team leader of all the work to be done that month as recorded on the fourteen (14) day 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 month, and the team leader will be responsible for assuring that all tasks are completed.

13.2.6 During the monthly organizational staff meeting the team and individual served will review the current needs and preferences of the individual served. The ICM team shall revise person directed recovery plans based on the current needs and preferences of the individual served (as needed), anticipate emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised recovery plans.

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

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

13.3.2 Occur and be scheduled when the individual and the majority of the team members can attend, including the psychiatric prescriber, team leader, and available members of the team. These meetings may also include the individual's family and/or natural supports, if available and at the request of the individual and require individual staff members to be present and systematically review and integrate individual information into a holistic analysis and work with the individual and team to establish priorities for services.

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

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

13.3.3.2 to problem-solve treatment strategies and rehabilitation options;

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

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

13.3.3.4.1 updated, at a minimum, every one-hundred-eighty (180) days;

13.3.3.4.2 Signed and dated by the individual, psychiatric prescriber, team leader and primary care manager(s).

14 Staff Supervision

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

14.1.1 Individual, side-by-side sessions in which the Team Leader accompanies an individual staff member on a quarterly basis to meet with individuals in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative service approaches;

14.1.2 Participation with team members in daily (for ACT) and weekly (for ICM) organizational staff meetings and regularly scheduled recovery planning meetings to review and assess staff performance and provide staff direction regarding individual cases;

14.1.3 Regular, formal supervisory meetings with individual staff members or in group setting to review their work with individuals, assess clinical performance, and give feedback;

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

14.1.5 Written documentation of all clinical supervision provided to ACT and ICM team staff shall be completed and maintained in the appropriate individual and/or employee file.

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

15 Assessment

15.1 **Initial Assessment:** An initial assessment and recovery plan shall be done within twenty-four (24) hours of the individual's admission to ACT or ICM by the team leader or the, psychiatric prescriber with participation by designated team members.

15.2 **Comprehensive Assessment:** A complete bio-psycho-social (BPS) assessment shall be completed by a Mental Health Professional. A team member with training in specific areas on the BPS may complete the section of the BPS that is their area of expertise (e.g. the Chemical Dependency Specialist may complete the Substance Abuse history section of the BPS). A comprehensive assessment shall be initiated and completed in collaboration with the individual within thirty (30) days after a individual's admission according to the following requirements:

15.2.1 *Psychiatric History, Mental Status, and Diagnosis:* The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment (which includes the most up-to-date DSM V diagnosis. The psychiatric prescriber presents the assessment findings at the first recovery planning meeting including:

- 15.2.1.1 the individual's strengths;
- 15.2.1.2 the extent and effects of drug and/or alcohol use;
- 15.2.1.3 medical, dental, and optometric needs;
- 15.2.1.4 adherence to and response to prescribed medical/psychiatric treatment;
- 15.2.1.5 recent key life events;
- 15.2.1.6 vocational and educational functioning;
- 15.2.1.7 history of trauma;
- 15.2.1.8 family history and social supports;
- 15.2.1.9 current social functioning;
- 15.2.1.10 legal history to include current legal issues;
- 15.2.1.11 financial status, including eligibility/access to entitlements;
- 15.2.1.12 conditions of daily living, including:
 - 15.2.1.12.1 housing;
- 15.2.1.13 recommendations for treatment to include issues to be:
 - 15.2.1.13.1 addressed,
 - 15.2.1.13.2 Referred; and

15.2.1.13.3 deferred.

15.2.2 *Education and Employment*: Included in this area is the assessment of community inclusion and integration as it relates to education and employment. The vocational specialist may present the assessment findings at the first recovery planning.

15.2.3 *Social Development and Functioning*: Included in this area is the assessment of the individual's social and interpersonal inclusion and integration within the community. The team member who does the assessment presents the assessment findings at the first recovery planning meeting.

15.2.4 *Instrumental Activities of Daily Living (IADL)*: Included in this area is an assessment of the individual's abilities and barriers in meeting day to day activities for independence. This includes but is not limited to:

15.2.4.1 Budgeting and money management

15.2.4.2 Shopping for groceries and other personal needs

15.2.4.3 Housekeeping

15.2.4.4 Personal care (bathing, grooming etc...)

15.2.4.5 Laundry

15.2.4.6 Other activities required for independent living.

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

15.2.5.1 Housing assessment made available to DSAMH upon request.

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

15.2.6.1 Personal skills, and talents;

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

15.2.7 While the assessment process shall involve the input of most, if not all, team members, the individual's psychiatric prescriber, team leader and team will assume responsibility for preparing the written narrative.

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

- 15.2.8.1 the primary care manager completing the evaluation;
- 15.2.8.2 the psychiatric prescriber; and
- 15.2.8.3 the team leader.

15.3 During the formulation of the assessment, the team will solicit feedback from the individual and obtain their signature indicating their participation in the assessment process.

15.4 A copy of the signed assessment shall be made available to the individual.

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

- 15.5.1 Assess the individuals readiness for transition to less intensive services;
- 15.5.2 Ensure a gradual, individualized process which ensures continuity of care and preservation of consumer preferences when transitioning to less intensive services;
- 15.5.3 Monitor the status of the transition once the individual is being served by another program, based on the individual need for such monitoring, and at a minimum of thirty (30) days.

15.5.4 Develop provisions for the individual to return to the team when a return to more intensive services is needed.

16 Physical Examination and Follow Up Medical Care

16.1 Individuals who have not had a physical examination within one year (365 days) prior to admission shall have a physical examination within sixty (60) days following admission to the program.

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

16.1.2 The current physical examination shall be reviewed, signed, and dated by the physician or other qualified medical personnel whose license allows them conduct and/or review physical examinations without oversight from a physician.

16.1.3 Areas for wellness improvement identified as a result of exam, including any recommendations for follow-up primary or specialty medical care will be shared with the individual for possible inclusion in the individuals person directed recovery plan (PDRP) and will be documented in the individual record.

16.2 The ACT and ICM teams will assist individuals in maintaining optimal physical health by assisting with:

16.2.1 Scheduling annual physicals including lab work and testing as determined necessary by the physician;

16.2.2 Making and keeping medical appointments;

16.2.3 Transportation to medical appoints when:

16.2.3.1 The individual is unable to independently attend appointments;

16.2.3.2 Is unable to understand the advice of their medical doctor and is need of an advocate for medical care;

16.2.3.3 Development of goals and objectives to address medical care in the individuals Person directed recovery plan.

17 Person-Directed Recovery Planning

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

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

17.1.1.1 his/her preferred natural supporters;

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

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

17.2.1 strengths,

17.2.2 needs,

17.2.3 abilities, and

17.2.4 preferences.

17.3 The PDRP shall:

17.3.1 identify individual strengths and capacities;

17.3.2 identify individual service needs;

17.3.3 for each service need, set specific and measurable:

17.3.3.1 long- and short-term goals;

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

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

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

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

17.4 ACT and ICM team staff shall meet at regularly scheduled times for recovery planning meetings. The Team Leader shall conduct the recovery planning meetings.

17.5 ACT and ICM staff shall make every effort to ensure that the individual and his/her family and/or natural supports (if desired by the individual) are in attendance at the recovery planning meeting.

17.6 Teams are responsible to provide the necessary support to ensure the individual is actively involved in the development of:

17.6.1 Recovery and service goals; and

17.6.2 Participation in the recovery plan meetings. This may include:

17.6.2.1 offering of peer-based coaching and/or

17.6.2.2 Skills training around his/her role in developing his/her own person directed recovery plan.

17.6.3 With the permission of the individual, ACT and ICM team staff shall also involve pertinent agencies and members of the individual's social network in the formulation of recovery plans.

17.6.4 Each individual's PDRP shall identify:

17.6.4.1 service needs,

17.6.4.2 strengths/barriers to success, and

17.6.4.3 goals that are:

17.6.4.3.1 specific and

17.6.4.3.2 measurable.

17.6.5 The PDRP must clearly specify:

17.6.5.1 The approaches and interventions necessary for the individual to achieve the individual goals (i.e., recovery)

17.6.5.2 The approaches and interventions that are contraindicated;

17.6.5.3 identify who will carry out the approaches and interventions.

17.6.6 The following key areas should be addressed in every individual's PDRP unless they are explored and designated as "not of current interest" with signature by the individual:

17.6.6.1 psychiatric illness

17.6.6.2 symptom reduction;

17.6.6.3 housing;

- 17.6.6.4 IADL;
- 17.6.6.5 daily structure and employment;
- 17.6.6.6 family and social relationships;
- 17.6.6.7 physical health; and
- 17.6.6.8 other life areas, goals and aspirations as identified by the individual (e.g., community activities, empowerment, decision-making, educational goals and aspirations, economic improvements etc.)

17.6.7 The individual's own words are reflected in the recovery plan.

17.7 The primary care manager and the team, together with the individual, will be responsible for conducting a recovery plan review during which the existing recovery plan is reviewed and the recovery goals and PDRP are rewritten or otherwise adjusted when there is a major decision point in the individual's course of treatment (e.g., significant change in individual's circumstances), and

17.7.1 At a minimum of every one hundred and eighty (180) days.

17.8 The Team Leader shall prepare a summary in conjunction with every recovery plan review (recovery plan summary) which documents the individual's and the team's:

- 17.8.1 Reasons for the review (regular review date or described change in circumstance);
- 17.8.2 evaluation of his/her progress/goal attainment,
- 17.8.3 evaluation of effectiveness of the interventions,
- 17.8.4 satisfaction with services since the last recovery plan.

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

- 17.9.1 the individual,
- 17.9.2 the primary care manager,
- 17.9.3 the team leader, and
- 17.9.4 the psychiatric prescriber

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

18 Core ACT/ICM Services

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

18.2 Services shall minimally include the following:

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

18.2.1.1 to work with the individual to write the person-directed recovery plan,

18.2.1.2 to provide individual supportive counseling,

18.2.1.3 to offer options and choices in the recovery plan,

18.2.1.4 to ensure that immediate changes are made as the individual's needs change, and

18.2.1.5 to advocate for the individual's wishes, rights, and preferences.

18.2.1.6 to act as principle contact and educator.

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

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

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

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

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

18.2.1.9.2 play an active role in treatment decision making,

- 18.2.1.9.3 be allowed to take risks;
- 18.2.1.9.4 make mistakes and
- 18.2.1.9.5 learn from those mistakes.

18.3 Crisis Assessment and Intervention

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

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

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

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

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

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

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

18.4.1 Psychoeducation regarding:

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

18.4.1.2 mental illness;

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

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

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

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

18.4.4 Psychotherapy, including:

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

18.4.4.2 and family therapy when appropriate.

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

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

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

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

18.5.3 Psychoeducation and providing the individual with practical information about mental illness and the individual's diagnoses and experiences with mental illness.

18.5.4 Training in individual's legal rights, civil and human rights including rights under the ADA and Olmstead and how to access assistance in achieving these rights.

18.5.5 Skills training and practice:

18.5.5.1 developing social supports;

- 18.5.5.2 understanding and implementing individual coping skills to decrease stress;
- 18.5.5.3 effectively using medication;
- 18.5.5.4 developing a personal definition of relapse;
- 18.5.5.5 identifying triggers for relapse and
 - 18.5.5.5.1 creating strategies for reducing relapse frequency and severity;
- 18.5.5.6 identifying personal stressors and coping positively with those stressors.
- 18.5.5.7 identifying and coping with symptoms.
- 18.5.5.8 getting individual needs met within the mental health system, including empowerment and self-advocacy.
- 18.5.5.9 learning and practicing new skills as they are developed with direct assistance.

19 Medication Prescription, Administration, Monitoring and Documentation

19.1 The ACT and ICM team's psychiatric prescriber shall:

19.1.1 Establish a direct and personal clinical relationship with each individual

19.1.2 Assess each individual's mental illness symptoms and provide verbal and written information about mental illness.

19.1.3 Review clinical information with the individual, and as appropriate, with the individual's family members or significant others;

19.1.4 Make an accurate diagnosis based on direct observation, available collateral information from the family and significant others and a current comprehensive assessment.

19.1.5 Provide a diagnostic work-up that will dictate an evidence-based medication pathway that the psychiatric prescriber will follow.

19.1.6 provide to the individual, and as appropriate, the individual's family and/or significant others, practical education about medication, including:

19.1.6.1 benefits and

19.1.6.2 risks of various medication strategies.

19.1.7 consider the preferences of the consumer with regard to medications that are incorporated in the individual's service plan;

19.1.8 devise a medication regimen that will help promote the consumer's engagement and ability to self-manage medications;

19.1.9 obtain informed consent from the individual for all medications prescribed.

19.1.10 In collaboration with the individual, assess, discuss and document the individual's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects.

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

19.2.1 Observations will be reviewed with the individual.

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

19.3.1 Record physician orders;

19.3.2 Order medication;

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

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

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

19.3.6 Administer medications per Delaware Board of Nursing AWSAM protocols.

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

20 Co-Occurring Disorders Services

20.1 ACT and ICM individuals will receive a comprehensive chemical dependency assessment during the first thirty (30) days of treatment. The assessment will include:

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

20.2 Treatment will follow a harm reduction model. This shall include, but not be limited to:

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

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

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

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

21 Education Services:

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

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

22 Vocational Services:

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

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

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

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

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

22.1.3 Job development activities.

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

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

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

23 Instrumental Activities of Daily Living Services

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

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

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

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

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

23.1.7.3 Perform household activities, including:

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

23.1.7.4 Carry out personal hygiene and grooming tasks, as needed

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

23.1.7.6 Use available transportation

23.1.7.7 Have and effectively use a personal physician and dentist.

23.2 Housing Services – the team shall provide housing services, utilizing the supportive housing model. In addition to the housing–related ADL services outlined above, services include the following:

23.2.1 Directly assisting individuals 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 individual rights of tenancy, whenever possible

24 Social and Community Integration Skills Training

- 24.1 Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skills training and include:
 - 24.1.1 supportive individual therapy (e.g., problem solving, role-playing, modeling, and support);
 - 24.1.2 social-skill teaching and assertiveness training;
 - 24.1.3 planning, structuring, and prompting of social and leisure-time activities;
 - 24.1.4 side-by-side support and coaching;
 - 24.1.5 organizing individual and group social and recreational activities to structure individuals' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:
 - 24.1.5.1 Improve communication skills,
 - 24.1.5.2 develop assertiveness, and increase self-esteem, as necessary
 - 24.1.5.3 increase social experiences, and
 - 24.1.5.4 where appropriate, develop meaningful personal relationships
 - 24.1.5.5 Plan appropriate and productive use of leisure time
 - 24.1.5.6 Relate to landlords, neighbors, and others effectively
 - 24.1.5.7 Familiarize themselves with available social and recreational opportunities
 - 24.1.5.8 and increase their use of such opportunities

25 Peer Support Services

- 25.1 These include services to validate individuals' experiences and to guide and encourage individuals to take responsibility for, and actively participate in their own recovery, as well as services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma. Peer Support and Wellness Recovery Services include:
- 25.1.1 Coaching in the development of Wellness Recovery Action Plan, and provision of other empirically supported peer-based, recovery approaches, such as Whole Health Action Management (WHAM) and Health and Recovery Peer Program (HARP)
 - 25.1.2 Peer counseling and support services, including those which:
 - 25.1.2.1 Promote self-determination and
 - 25.1.2.2 Encourage and reinforce choice and decision making.
 - 25.1.3 Introduction and referral to individual self-help programs and advocacy organizations that promote recovery.
 - 25.1.4 Assist individuals in self-advocacy and self-directed treatment planning.
- 25.2 The Peer Specialist will serve as a full team member to support a culture of recovery in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, support, and community activities.

26 Psychoeducation and Support of the Family and Supporters

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

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

27 Documentation of Services

27.1 The ACT and ICM team will document all services provided to individual and family in the individual file on forms approved by DSAMH. In addition to documentation of each contact, a narrative summary of the services provided to the individual shall be entered into the individual chart monthly and include:

27.1.1 A minimum of four (4) hours of services provided per month for ACT individuals. If a less intense level of service is provided to an individual over the course of a six-month period, due to the persons' recovery progress, the ACT team will demonstrate that it is implementing a timely process of assisting the individual in making the transition to a lower level of care;

27.1.2 A minimum of 2.5 hours of services provided per month for ICM individuals;

27.1.3 Individual's response to the services provided;

27.1.4 Progress in meeting recovery plan goals;

27.1.5 Changes in recovery plan goals;

27.1.6 Plans for continuation of care during the coming month;

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

28 ORGANIZATIONAL STANDARDS

28.1 Community care management programs shall establish an advisory committee, which meets at least quarterly and includes fifty (50%) peer and program individuals. The remaining members of the advisory committee shall be family members of individuals within its membership and other natural supports. The function of the advisory committee shall be to ensure individual and family participation in the process of setting and evaluating the values, mission, goals, objectives and service strategies of the program and to assist the program in representing its interest to the community in which it operates.

28.2 The advisory committee shall have written rules governing the conduct of its meetings which specify at least the following:

28.2.1 Its authority and duties;

28.2.2 Officers and committees;

28.2.3 Criteria, types, methods of membership;

28.2.4 Frequency of meetings;

28.2.5 Attendance requirements.

28.2.5.1 Minutes of advisory committee meetings shall be kept and shall include the following:

28.2.5.1.1 Date of meeting;

28.2.5.1.2 Attendance;

28.2.5.1.3 Topics discussed

28.2.5.1.4 Decisions reached;

28.2.5.1.5 Actions planned or taken;

28.2.5.1.6 Reports from sub-committees.

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

28.3.1 They shall maintain a Certificate of Occupancy;

28.3.2 They shall meet all applicable fire and life safety codes;

28.3.3 They shall be maintained in a clean and safe condition;

28.3.4 They shall provide rest rooms maintained in a clean and safe condition available to individuals, visitors and staff;

- 28.3.5 They shall be accessible to the individual served;
- 28.3.6 They shall provide a smoke free environment.

29 Individual Rights and Grievance Procedures

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

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

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

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

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

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

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

29.3.1.2 A standardized process for accepting and investigating grievances;

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

29.3.2.1 Provide for its availability to DSAMH upon request.

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

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

30 ADMINISTRATIVE STANDARDS

30.1 Individual Records

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

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

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

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

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

30.6 The active individual record shall contain the following:

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

30.6.2 An up-to-date face sheet;

30.6.3 Consent to treatment signed by the individual;

30.6.4 Consent to any occasion of release of information;

30.6.5 Documentation that the individual has been informed of his/her rights and the consumer's level of understanding of these rights;

30.6.6 Documentation that the individual has been provided with information regarding the process by which grievances can be addressed;

30.6.7 Copies of any grievances filed by the individual;

- 30.6.8 Reports from all examinations, tests and clinical consults;
- 30.6.9 Hospital discharge summaries;
- 30.6.10 Comprehensive medical psychosocial evaluation;
- 30.6.11 Comprehensive recovery plan/recovery plan updates;
- 30.6.12 Crisis intervention plan and updates;
- 30.6.13 The consumer's Advance Directive or other documentation of measures to be taken in the event of incapacity
- 30.6.14 Summary of monthly individual activity;
- 30.6.15 Progress notes;
- 30.6.16 Documentation of clinical supervision;
- 30.6.17 Medication records;
- 30.6.18 Discharge documentation.

31 Performance improvement Program

31.1 The ACT/ICM programs shall prepare an annual performance improvement plan, which shall be subject to approval by the Division. A clinician employed by the program or parent organization shall be designated performance improvement coordinator. The provider shall establish the performance improvement mechanisms below which shall be carried out in accordance with the performance improvement plan:

- 31.1.1 A statement of the program's objectives. The objectives shall relate directly to the program's individuals or target population.
- 31.1.2 Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
- 31.1.3 Methods for documenting achievements related to the program's stated objectives.
- 31.1.4 Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
- 31.1.5 In addition to the performance improvement and program evaluation plan, the ACT and ICM team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.
- 31.1.6 The ACT and ICM team shall maintain performance improvement and program evaluation policies and procedures that include:
 - 31.1.6.1 a concurrent utilization review process;
 - 31.1.6.2 a retrospective performance improvement review process;
 - 31.1.6.3 a process for clinical care evaluation studies; and
 - 31.1.6.4 a process for self-survey for compliance with the certification standards and TMACT Fidelity as prescribed by the Division.

31.2 The ACT and ICM team(s) shall ensure that data on the individual individual's race, ethnicity, spoken and written language, sexual orientation, and gender expression are collected in health records, integrated into the organization's management information systems, and are periodically updated.

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

32 WAIVER OF PROVISIONS

- 32.1 The Division Director of DSAMH or her/his designee, may issue a waiver of any of the discretionary requirements, with the exception of those that flow directly from external agencies such as those that administer Medicaid, of these certification standards upon the good-cause-shown request of a program seeking certification/re-certification. Such request for a waiver must demonstrate that the waiver will not in any substantial or material manner have a deleterious effect on the essential quality of services to the individual and shall offer an alternative procedure for the standard for which the waiver is requested.
- 32.2 Waivers issued by the Director or her/his designee shall be in writing and shall specify the maximum duration of the waiver's effect. No waivers may be done that exceed the purpose or scope of practice for Peer Staff.
- 32.3 Any waiver issued by the Director or her/his designee may be rescinded at any time at the discretion of the Director and will be rescinded if deleterious effect on the essential quality of service to the individual is evidenced. Any rescission will be made in writing and specify the date of revision.
- 32.4 Extensions and/or renewals of any waiver shall be made at the Director's discretion.