

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

Intensive Case Management (ICM)

**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 Intensive Case Management (ICM) programs for persons with psychiatric disabilities. DSAMH certification is required for provider enrollment within the Division of Social Services, Delaware Division of Medicaid and Medical Assistance (DMMA) for Medicaid reimbursement through the rehabilitative services option of Title XIX of the Social Security Amendments.

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

The DMMA Program requires providers of behavioral health rehabilitative services to be certified by DSAMH as a condition of enrollment before they may provide services to eligible Medicaid recipients. Behavioral Health rehabilitative services are medically related treatments, rehabilitative and support services for persons with disabilities caused by mental illness and substance use disorders. Intensive Case Management (ICM) is a type of community support program that the Division certifies as part of the criteria for Medicaid provider enrollment. Services are provided for as long as is medically necessary to assist service recipients to manage the symptoms of their illnesses, minimize the effects of their disabilities on their capacity for independent living, and prevent or eliminate periods of inpatient treatment.

1 Certification for Provider Participation

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

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

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

Beneficiary is an adult, age eighteen (18) or older, who is receiving person-centered treatment, rehabilitation, and support services through PROMISE.

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

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

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Certified Peer Recovery Specialist (CPRS) is an individual with personal, lived experience with their own recovery, who has completed the process for certification. The role of the CPRS uses a collaborative and strength-based approach, with the primary goal of assisting beneficiaries in achieving sustained recovery from the effects of mental health and/or substance use issues.

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

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

Clinical Supervision is a systematic process to review each beneficiary's clinical status and to ensure that the individualized services and interventions that the team members provide are planned with, purposeful for, effective, and satisfactory to the beneficiary. The team leader and the psychiatric prescriber have the responsibility for providing clinical supervision that occurs during 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 PDRP review and update, upon an individual entering 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 beneficiary and the family and/or support system, and other significant people to evaluate: 1) mental and functional status; 2) any substance use issues; 3) effectiveness of past treatment; 4) current treatment, rehabilitation and support needs to achieve beneficiary goals and support recovery; and, 5) 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 beneficiary 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 beneficiary; 2) set goals and develop the first person-directed recovery plan (PDRP) with each beneficiary; and, 3) optimize benefits that can be derived from existing strengths and resources of the beneficiary and his/her family and/or natural support network in the community.

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

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

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

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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 individualschedules.

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

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

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

EEU means the Eligibility and Enrollment Unit. The EEU functions as the "gatekeeper" for the Division of Substance Abuse and Mental Health's (DSAMH) levels of care. Individuals who wish to enroll in a DSAMH program must apply for services through the Eligibility and Enrollment Unit. The EEU evaluates each individual's need for these services based on a variety of criteria such as diagnosis, their history of mental illness and/or substance abuse, history of previous hospitalizations, and their ability to successfully function independently in the community.

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

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

ICM (Intensive Case Management) Team is a group of 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 a beneficiary and his/her family and/or natural supports in the community by the time of the first individual assessment and subsequent PDRP meeting. The ICM team serves individuals with a maximum staff to client ratio of 1:20. The ICM team serves beneficiaries referred from office-based outpatient care that require a higher level of support, as well as beneficiaries referred from ACT services that have successfully achieved increased independence.

The core members of the team are the primary case manager and the psychiatric prescriber, who share case coordination and service provision tasks for each beneficiary with the rest of the team. The team has an ongoing responsibility to be knowledgeable about the beneficiary's life, circumstances, goals and desires; to collaborate with the beneficiary 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 beneficiary's needs change; and to advocate for the beneficiary's wishes, rights, and preferences. The ICM team is responsible for providing much of the beneficiary's treatment, rehabilitation, and support services. Team members are assigned to take separate service roles with the beneficiary as specified by the beneficiary and the PDRP.

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Illness/Symptom Management is an approach designed to help each beneficiary 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.

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 beneficiary understands the purposes, risks and benefits of each medication or treatment prescribed, as well as his/her rights to refuse medication or treatment.

Initial Assessment and Person-Directed Recovery Plan is the initial evaluation of: 1) the beneficiary's mental and functional status; 2) any substance use issues; 3) the effectiveness of past treatment; 4) the current treatment, rehabilitation and support service needs, and 5) the range of individual strengths that can act as resources to the person and his/her team in pursuing goals. The results of the information-gathering and analysis are used to establish the initial recovery plan to achieve individual goals and support recovery. Completed the day of admission, the beneficiary's initial assessment and recovery plan guides team services until the comprehensive assessment and full PDRP is completed.

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

Interdisciplinary Approach is the service model whereby team members from multiple disciplines systematically collaborate and share their expertise across assessment and service activities. The purpose of this approach is to share responsibility for services and to integrate the expertise of team members, allowing beneficiaries to receive the specific evidence-based and client-centered services they need to achieve their goals. This approach requires continuous collaboration among all members (including the beneficiary and, if desired, his/her family/other natural supports) on a regular, planned basis.

Limited Lay Administration of Medications (LLAM) is a process by which LLAM trained unlicensed assistive personnel (UAP) help beneficiaries take and/or receive medication as ordered for the beneficiary by a licensed healthcare practitioner authorized to prescribe. Under Title 24, Chapter 19, medication administration is the responsibility of licensed registered nurses (RNs) and licensed practical nurses (LPNs). In the case of LLAM, medication administration is not a delegated duty by a RN or an LPN. All individuals acting under the LLAM program are the responsibility of the employer. Completing a LLAM course does not authorize an unlicensed individual to act beyond the scope of the LLAM training.

Medication Administration is the physical act of giving medication to beneficiaries by the prescribed route and in a manner consistent with state law and the licenses of the professionals that prescribe and/or administer medication (e.g., psychiatric prescribers, nurse practitioners, registered nurses, licensed practical nurses, and pharmacists).

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

Medication Assistance is the oversight of medication adherence where a member of the 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 Limited Lay Administration of Medication (LLAM) training at the beginning of employment and annually thereafter. Team members required to participate in LLAM training may not observe medication assistance prior to completing initial LLAM training during orientation and annual training thereafter. Peers may assist in medication assistance only when the team has determined that only the peer will have the most success in helping the beneficiary adhere to a prescribed medication regimen; this allowance must be time-limited, along with a plan to disengage the peer from providing this service, in addition to pre-approval by DSAMH.

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

Medication Management is a collaborative effort between the beneficiary and the psychiatric prescriber, with the participation of the team, to provide training in medication adherence and to carefully evaluate the beneficiary's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other 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 refers to an arrangement where a nurse who is licensed in one of the participating Compact(Multi- State) Licensure states can work in another of those 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 must **both** be parties to the compact agreement.

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 ICM team, which tailors service activity and intensity to meet the beneficiary's specific treatment, rehabilitation, and support needs. The written recovery plan documents the beneficiary's strengths, resources, self-determined goals, and the services necessary to help the beneficiary achieve them. The plan also delineates the roles and responsibilities of the team members who work collaboratively with each beneficiary in carrying out the services.

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

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

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manager also works with other community resources, including individually run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the beneficiary. The primary case 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 case manager is the first team member available to the beneficiary in crisis. The primary case manager shares these service activities with other members of the team who are responsible to perform them when the primary case manager is not working.

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

PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) is the DSAMH program that targets individuals with behavioral health needs and functional limitations to offer an array of home and community-based services (HCBS) that are person-centered, recovery-oriented, and aimed at supporting beneficiaries in the community. PROMISE will help improve clinical and recovery outcomes and reduce unnecessary institutional care through better care coordination, and thereby also reduce the growth in overall program costs.

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

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

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

PDRP Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of the meeting is for the staff, the beneficiary 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 beneficiary's life, his/her experience with mental illness/substance use, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each beneficiary and his/her goals and aspirations and for each beneficiary to become familiar with each team member; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; and to fully understand the recovery plan rationale in order to carry out the plan for each goal.

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

Social and Community Integration Skills Training provides support to beneficiaries 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 beneficiaries with mental illness/substance use disorders so that they may gain admission to and succeed in the pursuit of education including completing high school, (or obtaining a GED), post-secondary education and vocational school.

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

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

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

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

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

3 Admission and Discharge Criteria

- 3.1 Admission Criteria-All referrals to ICM are provided by the EEU. Eligible recipients are approved by the PROMISE Care Manager and certified by the psychiatric prescriber as being in medical need of program services in accordance with an assessment procedure approved by the Division.

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The assessment must provide supporting evidence of the following criteria:

- Target Criteria A and functional criteria A or C; or
- Target Criteria B and functional criteria B or C.

Specific diagnostic criteria can be found in Appendix A.

- 3.1.1 Documentation of admission shall include:
 - 3.1.1.1 Referral/approval by PROMISE Care Manager/EEU;
 - 3.1.1.2 Evidence that the criteria are met;
 - 3.1.1.3 The reasons for admission as stated by both the beneficiary and the team;
 - 3.1.1.4 The signature of the psychiatric prescriber;
 - 3.1.1.5 The return of the certification form to EEU.
 - 3.1.2 Engagement and enrollment into the ICM team will begin within five (5) days of referral.
 - 3.1.3 Note that the beneficiary will be considered to be admitted as of the initial intake appointment.
 - 3.1.4 After meeting with the prescriber, if there are any questions regarding the appropriateness of the referral, the ICM will contact PROMISE/EEU to discuss. If a change in level of care or referral is indicated, the beneficiary will remain enrolled with ICM under the alternative referral is made.
 - 3.1.5 Any exceptions to engagement or enrollment must be reported to PROMISE and the EEU; all documented engagement attempts shall be provided to DSAMH/EEU upon request.
 - 3.1.6 DMMA and DSAMH 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.
 - 3.1.7 Discharge planning starts at admission, with the eventual goal of moving to less intensive services.
- 3.2 Requests for Discharge from services shall occur when a beneficiary:
- 3.2.1 Has successfully reached individually established goals for discharge and demonstrates an ability to function in all major role areas such as work, social activities, and self-care, and when the beneficiary and program staff mutually agree to the transition to less intensive services;
 - 3.2.2 Is receiving less than the minimum of contact every fourteen (14) days and less than 2.5 hours of contact a month for 90 days;
 - 3.2.2.1 If this is due to the beneficiary's increased independence, there should be evidence in the PDRP that there is a plan for the beneficiary to step down to a lower level of care;
 - 3.2.2.2 If this is because the beneficiary is not engaging, the PDRP should show evidence of attempts to reengage the beneficiary;
 - 3.2.2.3 No beneficiary should remain with an ICM team longer than 90 consecutive days, if receiving less than the minimum contact per month.
 - 3.2.3 Moves outside the geographic area of ICM responsibility. In such cases, the ICM team shall arrange for transfer of mental health service responsibility to another provider wherever the beneficiary is moving. The ICM team shall maintain contact with the beneficiary until this service transfer is complete;
 - 3.2.4 Declines or refuses services and requests discharge, despite the team's documented best efforts to utilize appropriate engagement techniques to develop a mutually

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- acceptable PDRP with the beneficiary;
- 3.2.4.1 Prior to discharge from ICM services, the PROMISE Care Manager and the EEU shall approve and/or request further information to review the circumstances, the clinical situation, the risk factors, and attempted strategies to engage the beneficiary prior to the discharge of an beneficiary from ICM services.
- 3.2.5 In addition to the discharge criteria listed above, a beneficiary 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 beneficiary despite documented active outreach efforts by the team for a period of ninety (90) continuous days;
 - 3.2.5.3 Incarceration of ninety (90) days or more;
 - 3.2.5.4 When it has been determined that the beneficiary will not be appropriate for discharge from a hospital or nursing facility for a prolonged period of time. If the beneficiary is accessible at the time of discharge, the team shall ensure beneficiary participation in the discharge decisions, or document all attempts to obtain a signature. If the beneficiary is not able to actively participate, the decision to discharge will be mutually agreed between the hospital/facility, the ICM team, and with the approval of EEU/PROMISE.
- 3.2.6 The discharge summary shall include:
 - 3.2.6.1 Date of discharge;
 - 3.2.6.2 Reason for discharge;
 - 3.2.6.3 Beneficiary's status upon discharge based on the most recent assessment;
 - 3.2.6.3.1 DSM diagnosis;
 - 3.2.6.3.2 Summary of progress toward meeting goals as set forth in the beneficiary's PDRP;
 - 3.2.6.3.3 Documentation of the team's efforts to engage the beneficiary in services, when relevant to the reason for discharge;
 - 3.2.6.3.4 Aftercare/follow up plan completed in conjunction with the beneficiary;
 - 3.2.6.3.5 The beneficiary's contact information (e.g. forwarding address and/or phone number, email address).
- 3.2.7 The discharge summary shall be:
 - 3.2.7.1 Completed within five (5) business days of discharge from the ICM team;
 - 3.2.7.2 Signed and dated by:
 - 3.2.7.2.1 The beneficiary, when the discharge is planned;
 - 3.2.7.2.2 The primary case manager;
 - 3.2.7.2.3 The physician/prescriber; and
 - 3.2.7.2.4 The team lead.
- 3.2.8 The ICM team shall develop and implement beneficiary discharge plans, including referral/transfer to appropriate post-discharge services.

4 Service Intensity and Capacity

4.1 Staff-to-Individual Ratio ICM:

- 4.1.1 Each ICM team shall have the organizational capacity to provide a staff- to-beneficiary ratio of (1) full-time equivalent (FTE) staff person for every twenty (20) beneficiaries served by the team; *excluding the prescriber and program assistant.*

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4.2 Staff Coverage

4.2.1 Each 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.

4.2.2 Each ICM team shall have a minimum of one (1) Certified Mental Health Screener.

4.3 Frequency of Individual Contact

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

4.3.2 The ICM team shall have the capacity to provide multiple contacts per month but no less frequently than once every fourteen (14) days, for 2.5 contacts hours per month.

4.3.3 Any combination of categorical services can be counted toward the minimum of 2.5 hours (150 minutes); e.g.

4.3.3.1 Category 1 Physician (15 minutes)

4.3.3.2 Category 2 Master's level (60 minutes)

4.3.3.3 Category 3 Other practitioners (75 minutes)

4.3.4 Service levels of less than the minimum indicate the potential ability for the beneficiary to transfer to a lower level of care, or a need to reengage with the beneficiary. In either case, there should be a plan to reengage or transition documented in the PDRP. No beneficiary should remain with an ICM team longer than 90 continuous days, if receiving less than the minimum service hours per month.

4.4 The following services, identified by the use of DSAMH-acceptable tools, and as documented in the PDRP, will be provided:

4.4.1 Psychiatric and substance abuse treatment;

4.4.2 Psychiatric prescriber: Face-to-face evaluation after admission. Thereafter, beneficiaries who are being prescribed medications must be seen at least every sixty (60) days while beneficiaries who are not prescribed medications must be evaluated at least every six (6) months.

4.4.3 Chemical Dependency Specialist: At a minimum, face-to-face evaluation every fourteen (14) days for the first sixty (60) days after admission, and then as prescribed in the PDRP, that details on-going SUDs evaluation and interventions at a frequency and intensity appropriate to the severity of the substance use.

4.4.4 Mental health counseling: Availability of supportive counseling, or evidenced-based therapy provided by a Master's level clinician.

4.4.5 Medication monitoring, as follows:

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

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

4.4.5.3 Rationale for all changes in medication orders shall be documented in the prescriber's note.

4.4.5.4 All medication orders in the beneficiary's record shall specify:

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

- 4.4.5.4.2 Dosage;
- 4.4.5.4.3 Route of administration;
- 4.4.5.4.4 Frequency of administration;
- 4.4.5.4.5 Signature of the prescriber;
- 4.4.5.4.6 All known drug allergies.
- 4.4.5.4.7 Administration of medication by any method and/or the supervision of beneficiaries in the self-administration of medication must be conducted and documented in conformance with the program's written policies and procedures for medication management.
- 4.4.6 Programs shall utilize a DSAMH-approved Medication Administration Records (MAR) which shall contain the following:
 - 4.4.6.1 Name of all known prescribed medications (somatic or psychotropic), including brand or generic, if specified;
 - 4.4.6.2 Printed name and signature of prescriber;
 - 4.4.6.3 Dosage;
 - 4.4.6.4 Route of administration;
 - 4.4.6.5 Frequency of administration;
 - 4.4.6.6 All known drug allergies;
 - 4.4.6.7 Name of the person administering or assisting with the administration of medication;
 - 4.4.6.8 Signature of the person administering or assisting with the administration of medication.
- 4.4.7 Staff shall monitor and document beneficiary adherence to the prescribed medication treatment and any medication side effects, to include the following:
 - 4.4.7.1 Laboratory studies for all medications which require laboratory monitoring as recommended in the current Physician's Desk Reference;
 - 4.4.7.1.1 Laboratory reports shall:
 - 4.4.7.1.1.1 Be reviewed and signed by the prescriber or RN within two (2) days of receipt.
 - 4.4.7.1.1.2 Results of all laboratory studies shall be documented in the beneficiary's chart within 30 days.
- 4.4.8 For persons receiving antipsychotic medication:
 - 4.4.8.1 The Abnormal Involuntary Movement Scale (AIMS) shall be performed annually, at a minimum, to assess the beneficiary's risk for developing Tardive Dyskinesia;
 - 4.4.8.2 Beneficiaries prescribed atypical antipsychotic medications should be screened for metabolic disorders annually, at a minimum.
- 4.4.9 Education of beneficiaries regarding side effects of prescribed psychotropic medications and strategies for assuming responsibility for self-medication.
- 4.4.10 Monitoring of vital signs to include temperature, blood pressure, pulse, respiration, and weight at *every appointment with the prescriber, unless otherwise indicated*.
- 4.4.11 Measurement of Body Mass Index (BMI) at a minimal frequency of every six (6) months, as per American Psychiatric Association guidelines.
- 4.4.12 Metabolic assessment every (90) days for beneficiaries taking atypical antipsychotic medications (limited to assessment for diabetes mellitus and hypertension).
- 4.4.13 The program will use an evidence-based, trauma-informed assessment tool

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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 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 Ability to perform a psychiatric detention;
 - 5.1.1.6 Recovery and symptom management;
 - 5.1.1.7 Individual counseling and psychotherapy;
 - 5.1.1.8 Medication prescription, administration, monitoring, and documentation;
 - 5.1.1.9 Substance abuse counseling and co-occurring counseling;
 - 5.1.1.10 Supported housing assistance;
 - 5.1.1.11 Work-related and education-related services;
 - 5.1.1.12 Assistance with IADLs;
 - 5.1.1.13 Assistance with social, interpersonal, relationship, and leisure-time activity services;
 - 5.1.1.14 Support services or direct assistance to ensure that beneficiaries obtain the basic necessities of daily life;
 - 5.1.1.15 Education, support, and consultation to beneficiaries' families and other major supports; and
 - 5.1.1.16 Services that meet the requirements of the ADA/Olmstead ACT and their implications for practice.
- 5.1.2 The staff should have sufficient representation of, and cultural competence in, the local cultural population that the team serves.

6 ICM Required Staff

- 6.1 ICM teams must maintain the staff to beneficiary ratio of 1:20. The psychiatric prescriber and program/administrative assistant, although required as part of the team, are not counted in this ratio.
- 6.2 The following provides a description of and qualifications for required staff on all ICM teams:
 - 6.2.1 Team Leader: 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, psychology, or is a psychiatric prescriber.
 - 6.2.2 Psychiatric Prescriber may include:
 - 6.2.2.1 A person with a Medical Degree or Doctor of Osteopathy degree, licensed to practice medicine in Delaware, and who has completed, or is enrolled in, an accredited residency training program in psychiatry, internal medicine, or family practice.

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- 6.2.2.2 A psychiatric nurse practitioner who is licensed in the State of Delaware to diagnose mental health disorders and to prescribe psychotropic medications for such disorders and has a collaborative agreement for supervision with a psychiatrist.
- 6.2.3 Registered Nurses: All registered nurses shall be licensed in the State of Delaware or participating in the Nurse Licensure Compact (NLC). A minimum of 1 FTE RN is required.
- 6.2.4 Master's Level Mental Health Professionals: A minimum of two (2) FTE Master's level or above mental health professionals (in addition to the team leader) is required on the ICM team.
- 6.2.5 Chemical Dependency Specialist: One (1) or more team members must be Chemical Dependency Specialist(s) with:
 - 6.2.5.1 Certification in the state of Delaware as a Certified Alcohol and Drug Counselor (CADC) or Certified Advanced Alcohol and Drug Counselor (CAADC); or
 - 6.2.5.2 At least three (3) years of supervised work experience in the substance abuse treatment field; and,
 - 6.2.5.3 Enrollment and completion of CADC or CAADC within eighteen (18) months of hire.
- 6.2.6 Certified Peer Recovery Specialists (CPRS): CPRS are people that have lived experience with mental illness, substance use, treatment systems, and recovery. A minimum of one (1) FTE CPRS is required on an ICM team. Because of his/her life experience, the CPRS provides expertise that professional training cannot replicate. CPRS are fully integrated team members who provide highly individualized services in the community and promote beneficiary self-determination and decision making. They also provide essential expertise and consultation to the entire team to promote a culture in which each beneficiary's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities.
- 6.2.7 Remaining Clinical Staff: The remaining clinical staff will include a minimum two (2) FTE Bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions, including (1) FTE housing specialist. It is recommended that the housing specialist have a minimum of one (1) year experience in interviewing housing applicants and determining their eligibility for low-income housing and related services.
 - 6.2.7.1 A Bachelor's level mental health worker has a Bachelor's degree in social work or behavioral science, and work experience with adults with severe and persistent mental illness.
 - 6.2.7.2 A paraprofessional mental health worker may have:
 - 6.2.7.2.1 a Bachelor's degree in a field other than behavioral sciences; or
 - 6.2.7.2.2 have a high school degree and a minimum of two (2) years' work experience with adults with severe and persistent mental illness or with beneficiaries with similar human-service 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.

7 Policy and Procedure Requirements:

- 7.1 The 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:
- 7.1.1 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, to include:
 - 7.1.1.1 Policies and procedures that continually assess the program to assure:
 - 7.1.1.1.1 A trauma informed and responsive environment;
 - 7.1.1.1.2 An environment that is culturally sensitive to the populations that the programs serves including ethnic/cultural/religious minorities and LGBTQ beneficiaries;
 - 7.1.1.1.3 Referral policies and procedures that facilitate beneficiary referral;
 - 7.1.1.1.4 Detailed procedures for assessment, recovery planning, and documentation.
 - 7.1.2 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:
 - 7.1.2.1 Prescribing medication;
 - 7.1.2.2 Storage of medication;
 - 7.1.2.3 Handling of medication;
 - 7.1.2.4 Distribution of medication;
 - 7.1.2.5 Disposing of medication;
 - 7.1.2.6 Recording of medication used by beneficiaries;
 - 7.1.2.7 Assistance with medication in accordance with LLAM;
 - 7.1.3 Policies and procedures for handling on-call responsibilities and individual emergencies to include:
 - 7.1.3.1 Specific program standards for intervention to avert hospitalization, criminal justice system involvement, or other harmful outcomes.
 - 7.1.4 Policies and procedures for accessing and documenting the need for outside consultation to further the service goals or clinical needs of consumers;
 - 7.1.5 Detailed instructions for application to and communication with entitlement authorities including, but not limited to:
 - 7.1.5.1 The Social Security Administration;
 - 7.1.5.2 Social Services (e.g. SNAP, WIC, general relief, energy assistance);
 - 7.1.5.3 State Rental Assistance Program (SRAP), HUD/Section 8;
 - 7.1.5.4 Medicaid;
 - 7.1.5.5 Medicare;
 - 7.1.5.5.1 Low Income Subsidy (LIS);
 - 7.1.5.5.2 Part D Medicare;
 - 7.1.5.6 Prescription Assistance Program (PAP);
 - 7.1.5.7 Rep Payee (when applicable).
 - 7.1.6 Policies and procedures for obtaining releases to share Protected Health

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- Information about beneficiaries with family members or others;
- 7.1.7 Policies and procedures regarding communicating and handling financial resources of the program;
- 7.1.8 Policies and procedures regarding the coordination of financial activities with the beneficiary's representative payee for payment from the Social Security Administration;
- 7.1.9 Policies and procedures for the receipt, consideration, and resolution of individual complaints and/or grievances regarding treatment decisions and practices, or other program activities.
- 7.1.10 Policies and procedures for reporting instances of death, possible abuse or neglect, and adverse events to DHSS/DSAMH, law enforcement, and other entities in accordance with state and federal regulations and laws;
- 7.1.11 Policies and procedures for assisting beneficiaries in securing legal counsel or other special professional expertise when needed;
- 7.1.12 Policies and procedures for ensuring that beneficiaries are not subject to unwarranted coercion, including legal coercion (outpatient commitment, guardianship);
- 7.1.13 Policies and procedures to ensure that beneficiaries are afforded an opportunity to execute Advance Directives or medical or legal documents to ensure that their preferences are considered in the event of a crisis or temporary inability to make informed decisions;
- 7.1.14 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.

8 Personnel Management

- 8.1 The 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:
 - 8.1.1 Policies and procedures regarding equal employment opportunity and affirmative action to include compliance with:
 - 8.1.1.1 *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;
 - 8.1.1.2 Title XIX of Del section 711 prohibiting discrimination on the basis of race, color, creed, sex, sexual orientation, and national origin;
 - 8.1.1.3 Age discrimination Act of 1975 prohibiting discrimination based on age;
 - 8.1.1.4 Section 402 of the *Vietnam Era Veterans Readjustment Assistance Act* of 1974 prohibiting discrimination against disabled Vietnam Era veterans.
 - 8.1.2 Policies and procedures for interviews and selection of candidates including:
 - 8.1.2.1 Verification of credentials and references;
 - 8.1.2.2 Criminal background checks including:
 - 8.1.2.2.1 Registration on Adult Abuse and Child Abuse registries;
 - 8.1.2.3 Policies and procedures for employee performance appraisal including:
 - 8.1.2.3.1 A code of ethics;
 - 8.1.2.3.2 Conditions and procedures for employee discipline, including

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- termination of employment;
- 8.1.2.3.3 Conditions and procedures for employee grievances and appeals.
- 8.1.2.4 An annual staff development plan which shall include:
 - 8.1.2.4.1 Provisions for orientation of paid staff, student interns, and volunteers. Orientation shall include:
 - 8.1.2.4.1.1 Review of these standards;
 - 8.1.2.4.1.2 Review of the program's Procedures and Personnel manuals;
 - 8.1.2.4.1.3 LLAM training, in accordance with applicable rules and regulations;
 - 8.1.2.4.1.4 Review of DHSS Policy Memorandum #46;
 - 8.1.2.4.1.5 Review of section 5161 of Title 16 of the Delaware Code;
 - 8.1.2.4.1.6 Review of the *Health Insurance Portability and Accountability Act* of 1996, 45 C.F.R Parts 160 and 164;
 - 8.1.2.4.1.7 Review of the Substance Abuse Confidentiality regulations codified at 42 C.F.R. Part 2.
 - 8.1.2.4.1.8 Provisions for continuing education of staff;
 - 8.1.2.4.1.9 Provisions for regularly scheduled clinical supervision that teaches and enhances the clinical skills of staff, including:
 - 8.1.2.4.1.9.1 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;
 - 8.1.2.4.1.9.2 Individual face-to-face sessions between the team leader and staff to review cases, assess performance, and give feedback.
- 8.1.2.5 Maintenance and access to personnel files which shall contain employees' applications, credentials (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.
- 8.1.2.6 Annual validation of credentials.
- 8.1.2.7 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.
- 8.1.2.8 Work hours including hours of program operation, shifts and overtime compensation.
- 8.1.2.9 Agency policies regarding compensation, including:
 - 8.1.2.9.1 Salary ranges, salary increased, and payroll procedures;

- 8.1.2.9.2 Use of personal automobile for program activities;
- 8.1.2.9.3 Reimbursement for work-related expenses;
- 8.1.2.9.4 Description of employee benefits.

9 Hours of Operation and Staff Coverage

- 9.1 The ICM team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities 24 hours per day, seven days per week. This means:
 - 9.1.1 Mental health professionals on the ICM staff who are experienced in the program and skilled in crisis intervention procedures shall be on call to provide backup to on-call staff, and will be available to respond to beneficiaries by phone or by in-person visit to beneficiaries who need
- 9.2 The ICM team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities with 24 hours per day, seven days per week. This means:
 - 9.2.1 Mental Health Professionals on the ICM staff who are experienced in the program and skilled in crisis intervention procedures shall be on call to provide backup to on-call staff, and will be available to respond to beneficiaries by phone or by in-person visit to beneficiaries who need face-to-face contact.
 - 9.2.2 Regularly arranging for and providing psychiatric backup during all hours the prescriber is not scheduled to work. If availability of the ICM 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 department psychiatric prescriber).
 - 9.2.3 Adjusting schedules and providing staff to carry out the needed service activities in the evenings or on weekend days for beneficiaries for whom this is necessary;
 - 9.2.4 The ICM teams shall provide beneficiaries and significant others, as applicable and with consent of the beneficiary, information about how to access staff in the event of an emergency, including:
 - 9.2.4.1 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 if a face-to-face contact is needed.

10 Place of Treatment

- 10.1 ICM service contacts shall be provided in non-office-based or non-facility-based settings as deemed appropriate for each client, though it is expected that fifty percent (50%) of contacts will be outside of the office. 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.

11 Staff Communication and Planning

- 11.1 The ICM team shall conduct, at a minimum, weekly team meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted to formalize communication and update staff on treatment needs and/or changes of clients.
 - 11.1.1 The ICM team shall maintain a written or computerized log. The log provides:

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11.1.1.1 A roster of the beneficiaries served in the program, and for each beneficiary:

11.1.1.1.1 a brief documentation of any treatment or service contacts that have occurred during the last seven (7) days;

11.1.1.1.2 A concise, behavioral description of the beneficiary's status that week.

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

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

11.2 The ICM team shall conduct PDRP meetings under the supervision of the team leader and the psychiatric prescriber. These recovery planning meetings shall:

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

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

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

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

11.2.3.2 to problem-solve treatment strategies and rehabilitation options;

11.2.3.3 to participate with the beneficiary and the team in the development and the revision of the strengths based PDRP;

11.2.3.4 to fully understand the recovery plan rationale in order to carry out the plan with each beneficiary; and

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

11.2.3.4.2 Signed and dated by the beneficiary, psychiatric prescriber, team leader, primary case manager, and other natural, peer, or professional supports when necessary.

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

11.3 The ICM Team shall ensure direct communication with hospital staff when an ICM client is hospitalized. Communications shall include:

- 11.3.1 Direct communication from the ICM Team prescriber to the hospital Attending Physician.
- 11.3.2 Ongoing communication, at least once weekly between ICM Team staff and the hospital treatment team staff.
- 11.3.3 Direct communication regarding the pending date of discharge from the hospital and agreements for aftercare.
- 11.3.4 Ensuring that once notified of a beneficiary's discharge date, the beneficiary is discharged to appropriate community aftercare within 48 hours of the hospital's notification.

12 Staff Supervision

12.1 Each 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:

- 12.1.1 Participation with team members weekly, team meetings and regularly scheduled recovery planning meetings to provide staff direction regarding individual cases;
- 12.1.2 Monthly, formal supervisory meetings with individual staff members to review their work with beneficiaries, assess clinical performance, and give feedback;
- 12.1.3 Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, recovery plans, recovery plan reviews); and
- 12.1.4 Written documentation of all clinical supervision provided to team staff shall be completed and maintained by the Team Leader.
 - 12.1.4.1 Written documentation shall be signed and dated by the team leader at the time of the supervision session.

13 Evaluation & Assessment

13.1 **Initial Intake Evaluation:** Admission to the program begins at the initial intake appointment, followed by an initial crisis plan and initial recovery plan within twenty-four (24) hours of the beneficiary's admission to ICM by the team leader or by designated team members.

13.2 **Initial Psychiatric Assessment:** The first meeting between the beneficiary and the psychiatric prescriber, which confirms the diagnoses and medical necessity for this level of care.

13.3 **Comprehensive Assessment:** A complete bio-psycho-social (BPS) assessment shall be completed by a Mental Health Professional. A team member with training in specific areas on the BPS may complete the section of the BPS that is their area of expertise. A comprehensive assessment shall be initiated and completed in collaboration with the beneficiary within thirty (30) days after a beneficiary's admission according to the following requirements and findings presented at the first recovery planning meeting:

- 13.3.1 **Psychiatric History, Mental Status, and Diagnosis:** The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment (which includes the most up-to-date DSM V diagnosis).
- 13.3.2 **Substance Use & Addictive Behaviors:** the chemical dependency specialist shall

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complete this assessment to include:

- 13.3.2.1 Substance use history;
 - 13.3.2.2 Trauma history;
 - 13.3.2.3 Parental and familial substance use summary;
 - 13.3.2.4 Effects/impact of substance use;
 - 13.3.2.5 Functional assessment: role played by substances in the beneficiary's life;
 - 13.3.2.6 Factors that have contributed to past successes and relapses;
 - 13.3.2.7 Individual strengths;
 - 13.3.2.8 Social support network (including both individuals who use substances and people who support recovery);
 - 13.3.2.9 Beneficiary's self-identified goals and aspirations.
- 13.3.3 Education and Employment: Included in this area is the assessment of community inclusion and integration as it relates to education and employment.
- 13.3.3.1 Vocational and educational functioning.
- 13.3.4 Social Development and Functioning: Included in this area is the assessment of the beneficiary's social and interpersonal inclusion and integration within the community.
- 13.3.4.1 Current social functioning;
 - 13.3.4.2 Legal history, to include legal issues.
- 13.3.5 Instrumental Activities of Daily Living (IADL): Included in this area is an assessment of the beneficiary's abilities and barriers in meeting day to day activities for independence. This assessment includes, but is not limited to:
- 13.3.5.1 Budgeting and money management;
 - 13.3.5.2 Financial status, including eligibility/access to entitlements;
 - 13.3.5.3 Shopping for groceries and other personal needs;
 - 13.3.5.4 Housekeeping;
 - 13.3.5.5 Conditions of living:
 - 13.3.5.5.1 Adequate housing, with housing assessment available to DSAMH upon request;
 - 13.3.5.6 Personal care (bathing, grooming, etc.)
 - 13.3.5.7 Laundry
 - 13.3.5.8 Other activities required for independent living.
- 13.3.6 Family Structure and Relationships: Included in this area of the assessment is the extent to which family, friends, and other supports are currently involved in the beneficiary's care, and plans to include the family, friends, and other supports in treatment moving forward.
- 13.3.7 Strengths and Resources: Members of the beneficiary's ICM team are responsible for engaging the beneficiary in his or her own recovery planning in order to identify individual strengths and resources as well as those within the beneficiary's family, natural support network, service system, and community at large. These may include:
- 13.3.7.1 Personal skills and talents;
 - 13.3.7.2 Personal virtues and traits;
 - 13.3.7.3 Interpersonal skills;
 - 13.3.7.4 Interpersonal and environmental resources;
 - 13.3.7.5 Cultural knowledge,
 - 13.3.7.6 Knowledge gained by struggling with adversity;

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- 13.3.7.7 Knowledge gained through occupational and parental roles;
- 13.3.7.8 Spirituality and faith;
- 13.3.7.9 Hopes, dreams, goals, and aspirations.
- 13.3.8 While the assessment process shall involve the input of most, if not all, team members, the beneficiary's psychiatric prescriber and/or team leader will assure completion of the written narrative.
- 13.3.9 The Comprehensive Assessment shall be signed, and dated by:
 - 13.3.9.1 the primary case manager completing the evaluation;
 - 13.3.9.2 the team leader.
- 13.3.10 An up-dated, annual assessment shall be completed on each annual certification date for each beneficiary. In addition to the assessment requirements in §15.0 of these standards, the annual assessment shall:
- 13.3.11 Assess the beneficiary's readiness for transition to less intensive services;
 - 13.3.11.1 Review the progress achieved in accordance to the outcome-oriented recovery plan and reviewing what is required in order to continue in a recovery-based trajectory to a less intensive level of care;
 - 13.3.11.2 Ensure a gradual, individualized process which ensures continuity of care and preservation of beneficiary preferences when transitioning to less intensive services.

14 Physical Examination and Follow Up Medical Care

- 14.1 Beneficiaries who have not had a physical examination within one-year (365 days) prior to admission shall have a physical examination within sixty (60) days following admission to the program.
 - 14.1.1 Results of the current physical examination shall be documented in the individual record.
 - 14.1.2 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.
 - 14.1.3 Areas for wellness improvement identified as a result of exam, including any recommendations for follow-up primary or specialty medical care, will be shared with the beneficiary for possible inclusion in the beneficiary's PDRP and will be documented in the beneficiary record.
 - 14.1.4 The primary prescriber shall act as attending of record, holistically acknowledging all aspects of the beneficiary's health and wellness, and to provide care guidance to the team.
- 14.2 The ICM teams will assist beneficiaries in maintaining optimal physical health by assisting with:
 - 14.2.1 Scheduling annual physicals, including lab work and testing, as determined necessary by the physician;
 - 14.2.2 Making and keeping medical appointments;
 - 14.2.3 Transportation to medical appointments when the beneficiary:
 - 14.2.3.1 is unable to independently attend appointments;
 - 14.2.3.2 is unable to understand the advice of their medical doctor and is need of an advocate for medical care;
 - 14.2.3.3 has goals and objectives to address medical care in the beneficiary's PDRP.

15 Person-Directed Recovery Planning

- 15.1 Person directed recovery plans will be developed through the following process:
 - 15.1.1 The PDRP shall be developed in collaboration with the primary case manager, beneficiary, other members of the team, as chosen by the beneficiary, and:
 - 15.1.1.1 his/her preferred natural supports;
 - 15.1.1.2 and/or guardian, if any, when feasible and appropriate;
 - 15.1.1.3 will include recovery goals provided by PROMISE care manager. **
- 15.2 The beneficiary's participation in the development of the PDRP shall be documented; and ICM team shall evaluate together with each beneficiary their:
 - 15.2.1 strengths;
 - 15.2.2 needs;
 - 15.2.3 abilities, and
 - 15.2.4 preferences.
- 15.3 The PDRP shall:
 - 15.3.1 identify individual strengths and capabilities;
 - 15.3.2 identify beneficiary service needs;
 - 15.3.3 for each service need, set specific and measurable:
 - 15.3.3.1 long- and short-term goals;
 - 15.3.4 establish the specific approaches and interventions necessary for the beneficiary to meet his/her goals;
 - 15.3.5 improve his/her capacity to function as independently as possible in the community;
 - 15.3.6 seek to achieve the maximum level of recovery possible, as defined by the beneficiary (e.g., a meaningful, satisfying, and productive life); and
 - 15.3.7 identify interventions that have been helpful or that pose particular risks to the beneficiary.
- 15.4 ICM staff shall make every effort to ensure that the beneficiary and his/her family and/or natural supports (if desired by the beneficiary) attend the recovery planning meeting.
- 15.5 ICM staff shall invite other professional supports to attend in the recovery planning process, if the beneficiary would like their involvement (e.g. DSAAPD, methadone or other SUD treatment program(s), probation and parole, housing support programs, etc.).
- 15.6 ICM staff shall invite the PROMISE care manager to attend in recovery plan meeting. **
- 15.7 Teams are responsible to provide the necessary support to ensure the beneficiary is actively involved in the development of:
 - 15.7.1 Recovery and service goals; and
 - 15.7.2 Participation in the recovery plan meetings. This may include:
 - 15.7.2.1 offering of peer-based coaching; and/or
 - 15.7.2.2 Skills training around his/her role in developing his/her own PDRP.
 - 15.7.3 With the permission of the beneficiary, ICM team staff shall also involve pertinent agencies and members of the beneficiary's social network in the formulation of recovery plans.
 - 15.7.4 Each beneficiary's PDRP shall identify:
 - 15.7.4.1 service needs;
 - 15.7.4.2 strengths/barriers to success; and
 - 15.7.4.3 goals that are specific and measurable.
 - 15.7.5 The PDRP must clearly specify:
 - 15.7.5.1 the approaches and interventions necessary for the beneficiary to achieve their goals;

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- 15.7.5.2 the approaches and interventions that are contraindicated;
- 15.7.5.3 the identity of the individual who will carry out the approaches and interventions.
- 15.7.6 The following key areas should be addressed in every beneficiary's PDRP unless they are explored and designated as deferred or referred, with signature by the beneficiary:
 - 15.7.6.1 psychiatric illness management;
 - 15.7.6.2 symptom management;
 - 15.7.6.3 housing;
 - 15.7.6.4 IADLs;
 - 15.7.6.5 daily structure and employment;
 - 15.7.6.6 family and social relationships;
 - 15.7.6.7 physical health; and
 - 15.7.6.8 other life areas, goals and aspirations as identified by the beneficiary (e.g., community activities, empowerment, decision-making, educational goals and aspirations, economic improvements etc.).
- 15.7.7 The beneficiary's own words are reflected in the recovery plan, which may at times include an attached copy of goals written by the beneficiary.
- 15.7.8 Measurable goals with current status.
- 15.8 The primary case manager and the beneficiary will be responsible for ongoing review of the recovery plan and will rewrite or adjust the goals and the plan:
 - 15.8.1 when there is a significant change in the beneficiary's circumstances;
 - 15.8.2 at a minimum of every one hundred eighty (180) days.
- 15.9 The revised recovery plan will be signed by:
 - 15.9.1 the beneficiary;
 - 15.9.2 the primary case manager;
 - 15.9.3 the team leader; and
 - 15.9.4 the psychiatric prescriber.
- 15.10 A copy of the signed PDRP is made available to the beneficiary.

16 Core ICM Services

- 16.1 Operating as a continuous treatment service, the ICM team shall have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit.
- 16.2 At a minimum, services shall include the following:
 - 16.2.1 Service Coordination: Each beneficiary will be assigned a primary case manager who coordinates and monitors the activities of the beneficiary's team. The responsibilities of the primary case manager are:
 - 16.2.1.1 to work with the beneficiary to write the PDRP;
 - 16.2.1.2 to provide supportive counseling to the beneficiary;
 - 16.2.1.3 to offer options and choices in the recovery plan;
 - 16.2.1.4 to ensure that immediate changes are made as the beneficiary's needs change;
 - 16.2.1.5 to advocate for the beneficiary's wishes, rights, and preferences;
 - 16.2.1.6 to act as principle contact and educator.
 - 16.2.1.6.1 Members of the team share these tasks with the primary case manager and are responsible to perform the tasks when the primary case manager is not working.

- 16.2.1.7 to provide community liaison and coordination with community resources, including self-help and advocacy organizations that promote recovery;
- 16.2.1.8 to incorporate and demonstrate basic recovery values in the coordination of services;
- 16.2.1.9 to help ensure the beneficiary will have ownership of his or her own treatment and will be expected to:
 - 16.2.1.9.1 take the primary role in PDRP development;
 - 16.2.1.9.2 play an active role in treatment decision making,
 - 16.2.1.9.3 be allowed to take risks;
 - 16.2.1.9.4 make mistakes; and
 - 16.2.1.9.5 learn from those mistakes.

16.3 Crisis Assessment and Intervention

- 16.3.1 Crisis assessment and intervention shall be provided 24 hours per day, seven days per week.
- 16.3.2 The team must respond to notification of a crisis within 15 minutes.
- 16.3.3 These services will include telephone and face-to-face contact.
- 16.3.4 A minimum of one staff member on the ICM team shall be an active, certified mental health screener.
- 16.3.5 Crisis Intervention, CAPAC, and other programs may provide adjunctive crisis intervention.
- 16.3.6 A representative from the ICM team will be physically present to support the ICM beneficiary when external crisis responders are involved with the beneficiary.
- 16.3.7 Each ICM beneficiary will have an individualized, strengths-based crisis plan that shall be updated annually.
- 16.3.8 The beneficiary will take the lead role in developing the crisis plan.

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

- 16.4.1 Psychoeducation regarding:
 - 16.4.1.1 mental illness;
 - 16.4.1.2 substance use and co-occurring disorders, when appropriate;
 - 16.4.1.3 the effects of personal trauma history on mental health and recovery;
 - and
 - 16.4.1.4 the effects and side effects of prescribed medications.
- 16.4.2 Symptom management efforts directed to help each beneficiary identify/target the symptoms and occurrence patterns of his or her mental illness; and
- 16.4.3 Development of methods (internal, behavioral, or adaptive) to help lessen the effects.
- 16.4.4 Psychotherapy, including:
 - 16.4.4.1 individual supportive therapy;
 - 16.4.4.2 empirically supported psychotherapy interventions that address specific symptoms and behaviors, provided by a Master's level clinician; and,
 - 16.4.4.3 supportive family therapy, when indicated by the BPS or PDRP, also to include the beneficiary's informal support system, with the agreement of the beneficiary.

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16.4.5 Psychological support to beneficiaries, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to aid in recovery.

16.5 Wellness Management and Recovery Services shall include, but not be limited to, the following:

16.5.1 Defining and identifying the beneficiary's recovery goals within the beneficiary's frame of reference;

16.5.2 Developing strategies for implementing and maintaining the identified recovery goals as informed by the beneficiary's strengths;

16.5.3 Psychoeducation and providing the beneficiary with practical information about mental illness and the beneficiary's diagnoses and experiences with mental illness;

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

16.5.5 Skills training and practice:

16.5.5.1 developing social supports;

16.5.5.2 understanding and implementing individual coping skills to decrease stress;

16.5.5.3 effectively using medication;

16.5.5.4 developing a personal definition of relapse;

16.5.5.5 identifying triggers for relapse; and

16.5.5.5.1 creating strategies for reducing relapse frequency and severity;

16.5.5.6 identifying personal stressors and coping positively with those stressors;

16.5.5.7 identifying and coping with symptoms;

16.5.5.8 getting beneficiary needs met within the mental health system, including empowerment and self-advocacy;

16.5.5.9 learning and practicing new skills, as they are developed, with direct assistance.

17 Medication Prescription, Administration, Monitoring and Documentation

17.1 The ICM team's psychiatric prescriber shall:

17.1.1 establish a direct and personal clinical relationship with each beneficiary;

17.1.2 assess each beneficiary's mental illness symptoms and provide verbal and written information about mental illness;

17.1.3 review clinical information with the beneficiary, and as appropriate, with the beneficiary's family members or significant others;

17.1.4 make an accurate diagnosis based on direct observation, available collateral information from the family and significant others, and a current comprehensive assessment;

17.1.5 provide a diagnostic work-up that will dictate an evidence-based medication pathway that the psychiatric prescriber will follow;

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

17.1.6.1 benefits; and

17.1.6.2 risks of various medication strategies.

17.1.7 consider the preferences of the consumer with regard to medications that are

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- incorporated in the beneficiary's service plan;
- 17.1.8 devise a medication regimen that will help promote the beneficiary's engagement and ability to self-manage medications;
- 17.1.9 obtain informed consent from the beneficiary for all medications prescribed;
- 17.1.10 in collaboration with the beneficiary, assess, discuss, and document the beneficiary's mental illness symptoms and behavior in response to medication, and shall monitor and document medication side effects.
- 17.1.11 Prescribers should provide care in a professionally responsible manner, adhering to the practice guidelines of the American Psychiatric Association, the American Medical Association, and the American Osteopathic Association.
- 17.2 All ICM team members shall assess and document the beneficiary's behavior and response to medication and shall monitor for medication side effects.
 - 17.2.1 Observations will be reviewed with the beneficiary.
- 17.3 The ICM team program shall establish medication policies and procedures which identify processes to:
 - 17.3.1 record physician orders;
 - 17.3.2 order medication;
 - 17.3.3 arrange for all individual medications to be organized by the team and integrated into beneficiary's monthly schedules and daily staff assignment schedules;
 - 17.3.4 provide security for medications (e.g., long-term injectable, daily, and longer term);
 - 17.3.5 set aside a private designated area for set up of medications by the team's nursing staff;
 - 17.3.6 administer medications per Delaware Board of Nursing LLAM protocols;
 - 17.3.7 apply for Patient Assistance Plan (PAP) for all beneficiaries eligible for assistance.

18 Co-Occurring Disorders Services

- 18.1 ICM beneficiaries will receive integrated treatment that is:
 - 18.1.1 non-confrontational;
 - 18.1.2 considers interactions of mental illness and substance abuse; and
 - 18.1.3 results in a PDRP that incorporates goals determined by the beneficiary.
- 18.2 Treatment will follow a harm reduction model. This will include:
 - 18.2.1 individual and/or group interventions in:
 - 18.2.1.1 developing motivation for decreasing use;
 - 18.2.1.2 developing skills to minimize use;
 - 18.2.1.3 recognition of negative consequences of use; and
 - 18.2.1.4 adoption of an abstinence goal for treatment.
 - 18.2.2 Engagement (e.g., empathy, reflective listening);
 - 18.2.3 Ongoing assessment (e.g., stage of readiness to change, beneficiary- determined problem identification);
 - 18.2.4 Motivational enhancement (e.g., developing discrepancies, psycho- education);
 - 18.2.5 Active treatment (e.g., cognitive skills training, community reinforcement).
 - 18.2.6 Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

19 Education Services:

- 19.1 Supported Education:

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- 19.1.1 Supported education related services are for ICM beneficiaries whose high school, college or vocational education could not start or was interrupted and who wish to include educational goals in their recovery plan. Services provide support with:
 - 19.1.1.1 Enrolling and participating in educational activities;
 - 19.1.1.2 Pre-admission counseling to determine which school and/or type of educational opportunities may be available;
 - 19.1.1.3 Strengths-based assessment of educational interests, abilities, and history;
 - 19.1.1.4 If indicated, referral to GED classes and testing;
 - 19.1.1.5 Assistance with completion of applications and financial aid forms;
 - 19.1.1.6 Help with registration;
 - 19.1.1.7 Orientation to campus buildings and school services;
 - 19.1.1.8 Early identification and intervention with academic difficulties;
 - 19.1.1.9 Linking with academic supports such as tutoring and learning resources;
 - 19.1.1.10 Assistance with time management and schoolwork deadlines;
 - 19.1.1.11 Supportive counseling;
 - 19.1.1.12 Information regarding disclosing mental illness;
 - 19.1.1.13 Advocating with faculty for reasonable accommodations.

20 Vocational Services:

- 20.1 Vocational Services shall be provided or coordinated to include work-related services to help beneficiaries value, find, and maintain meaningful employment in ordinary community-based job sites, as well as job development and coordination with employers. When the beneficiary chooses to participate, services include but are not limited to:
 - 20.1.1 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;
 - 20.1.2 Assessment of the effect of the beneficiary's mental illness on employability with identification of specific behaviors that:
 - 20.1.2.1 help and hinder the beneficiary's work performance; and
 - 20.1.2.2 development of interventions to reduce or eliminate any hindering behaviors and find effective job accommodations.
 - 20.1.3 Job development activities;
 - 20.1.4 Development of an ongoing employment rehabilitation plan to help each beneficiary establish the skills necessary to find and maintain a job;
 - 20.1.5 Provision of on-the-job or work-related crisis intervention services;
 - 20.1.6 Other work-related supportive services, such as Supported Employment activities which may include: assistance with resume development, job application preparation, interview support, helping beneficiaries with job related stress, managing symptoms while at work, grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation.

21 Instrumental Activities of Daily Living Services

- 21.1 These are services to support activities of daily living in community-based settings to include:
 - 21.1.1 individualized assessment;
 - 21.1.2 problem solving;

- 21.1.3 skills training/practice;
- 21.1.4 sufficient side-by-side assistance and support;
- 21.1.5 modeling;
- 21.1.6 ongoing supervision (e.g. prompts, assignments, monitoring, encouragement);
- 21.1.7 environmental adaptations to assist beneficiaries to gain or use the skills required to:
 - 21.1.7.1 find housing (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating;) which is:
 - 21.1.7.1.1 safe;
 - 21.1.7.1.2 good quality;
 - 21.1.7.1.3 comfortable to the beneficiary;
 - 21.1.7.1.4 affordable, and
 - 21.1.7.1.5 in compliance with the *Americans with Disabilities Act* including the Olmstead Decision (28 C.F.R.§ 35.130).
 - 21.1.7.2 procure necessities (such as telephones, furnishings, linens);
 - 21.1.7.3 perform household activities, including:
 - 21.1.7.3.1 house cleaning;
 - 21.1.7.3.2 cooking;
 - 21.1.7.3.3 grocery shopping; and
 - 21.1.7.3.4 laundry.
 - 21.1.7.4 carry out personal hygiene and grooming tasks, as needed;
 - 21.1.7.5 develop or improve money-management skills with the goal of attaining independence in management of one's finances;
 - 21.1.7.6 use available transportation;
 - 21.1.7.7 have and effectively use a personal physician and dentist.

22 Social and Community Integration Skills Training

- 22.1 Social and community integration skills training serves to support social/interpersonal relationships and leisure-time skills training and includes:
 - 22.1.1 supportive individual therapy (e.g., problem solving, role-playing, modeling, and support);
 - 22.1.2 social-skill teaching and assertiveness training;
 - 22.1.3 planning, structuring, and prompting of social and leisure-time activities;
 - 22.1.4 side-by-side support and coaching;
 - 22.1.5 organizing individual and group social and recreational activities to structure beneficiaries' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:
 - 22.1.5.1 improve communication skills;
 - 22.1.5.2 develop assertiveness, and increase self-esteem;
 - 22.1.5.3 increase social experiences;
 - 22.1.5.4 encourage development of meaningful personal relationships;
 - 22.1.5.5 plan productive use of leisure time;
 - 22.1.5.6 relate to landlords, neighbors, and others effectively;
 - 22.1.5.7 familiarize themselves with available social and recreational opportunities; and
 - 22.1.5.8 enhance relationships with natural support systems.

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

- 22.2.1 directly assisting beneficiaries in locating housing of their choice, using a variety of housing options, including integrated, community-based, independent housing;
- 22.2.2 assistance in finding affordable, safe, and decent housing, which affords the individual rights of tenancy, whenever possible;
- 22.2.3 active intervention to assist and prevent issues that could cause loss of housing;
- 22.2.4 completion of the housing occupancy checklist quarterly.

23 Peer Recovery Specialist Services

23.1 These include services to validate beneficiaries' experiences, to guide and encourage beneficiaries to take responsibility for and actively participate in their own recovery, to help beneficiaries identify, understand, and combat stigma and discrimination against mental illness, and to reduce beneficiaries' self-imposed stigma. Peer Recovery Specialist Services include:

- 23.1.1 coaching in the development of empirically-supported, peer-based recovery approaches, such as the Wellness Recovery Action Plan (WRAP), Whole Health Action Management (WHAM) and Health and Recovery Peer Program (HARP).
- 23.1.2 peer counseling and support services, including those which:
 - 23.1.2.1 promote self-determination; and
 - 23.1.2.2 encourage and reinforce choice and decision making.
- 23.1.3 introduction and referral to individual self-help programs and advocacy organizations that promote recovery;
- 23.1.4 assisting beneficiaries in self-advocacy and self-directed treatment planning.

23.2 The Peer Recovery Specialists will serve as full team members to support a culture of recovery in which each beneficiary's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, support, and community activities.

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

- 23.3.1 When it is determined that peers are the best choice of staff on the ICM team to assist with medication adherence, the team must document the intervention in the PDRP, it must be time-limited, and pre-approved by DSAMH.

24 Psychoeducation and Support of the Family and Natural Supports

24.1 Services provided or coordinated under this category to beneficiaries' families and other major supports with beneficiary agreement or consent, include:

- 24.1.1 Individualized psychoeducation about the beneficiary's illness and the role of the family and other significant people in the therapeutic process;
- 24.1.2 Family intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people;
- 24.1.3 Ongoing communication and collaboration, face-to-face and by telephone, between the ICM team and the family;
- 24.1.4 Introduction and referral to family self-help programs and advocacy organizations that promote recovery;
- 24.1.5 Assistance to beneficiaries with their children, including individual supportive counseling, parenting training, and service coordination, including, but not limited

to:

- 24.1.5.1 Services to help beneficiaries throughout pregnancy and the birth of a child;
- 24.1.5.2 Services to fulfill parenting responsibilities and coordinating services for the child; and
- 24.1.5.3 Services to restore relationships with children who are not in the beneficiary's custody.

25 Documentation of Services

25.1 The ICM team will document all services provided to beneficiary and family in the beneficiary file.

- 25.1.1 Documentation of each contact/service provided to the beneficiary shall be entered into the beneficiary chart and shall be in accordance to best practice and include:
 - 25.1.1.1 A minimum of 2.5 hours of services provided per month for ICM beneficiaries;
 - 25.1.1.2 Contact no less frequently than 14 days, or more frequently, based on beneficiary need;
 - 25.1.1.3 A plan to step the beneficiary down to outpatient services within the next 90 days, if the contact is less than every fourteen days or less than 2.5 hours per month;
 - 25.1.1.4 services provided and the beneficiary's response to those services provided;
 - 25.1.1.5 progress in meeting recovery plan goals;
 - 25.1.1.6 coordination and communication related to beneficiary's care;
 - 25.1.1.7 changes in recovery plan goals;
 - 25.1.1.8 plans for continuation of care during the coming month;
 - 25.1.1.9 the date and the signature of the person entering the note into the beneficiary chart.

26 FACILITY STANDARDS

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

- 26.1.1 They shall post a Certificate of Occupancy;
- 26.1.2 They shall meet all applicable fire and life safety codes;
- 26.1.3 They shall be maintained in a clean and safe condition;
- 26.1.4 They shall provide rest rooms maintained in a clean and safe condition available to beneficiaries, visitors, and staff;
- 26.1.5 They shall be accessible to the beneficiary;
- 26.1.6 They shall provide a smoke free environment.

27 Beneficiary Rights and Grievance Procedures

27.1 ICM teams shall be knowledgeable about and familiar with individual rights including the beneficiaries' rights to:

- 27.1.1 Confidentiality;
- 27.1.2 Informed consent to medication and treatment;

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- 27.1.3 Treatment with respect and dignity;
- 27.1.4 Prompt, adequate, and appropriate treatment;
- 27.1.5 Treatment which is under the least restrictive conditions and which promotes beneficiaries' meaningful community integration and opportunities to live like ordinary Delawareans;
- 27.1.6 Nondiscrimination;
- 27.1.7 Control of own money;
- 27.1.8 Voice or file grievances or complaints.
- 27.2 ICM teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce beneficiary rights. These include:
 - 27.2.1 Grievance or complaint procedures under:
 - 27.2.1.1 Medicaid;
 - 27.2.1.2 DSAMH;
 - 27.2.1.3 *Americans with Disabilities Act*.
 - 27.2.1.4 Delaware Human Rights Commission and U.S. Department of Justice (Human Rights);
 - 27.2.1.5 U.S. Department of Housing and Urban Development (HUD-housing discrimination);
 - 27.2.1.6 PROMISE Care Manager** (see Manual)
- 27.3 ICM teams shall be prepared to assist beneficiaries in filing grievances with the appropriate organizations and shall:
 - 27.3.1 Have a grievance policy and procedure posted in a conspicuous and prominent area that includes:
 - 27.3.1.1 the names and phone numbers of beneficiaries who can receive grievances both at the agency and with other organizations;
 - 27.3.1.2 A standardized process for accepting and investigating grievances.
 - 27.3.2 Maintain documentation of the investigation and resolution of all grievances and;
 - 27.3.2.1 Provide for its availability to DSAMH upon request.
- 27.4 ICM teams should ensure that beneficiaries 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.
- 27.5 ICM teams will also ensure that beneficiaries receive services in their chosen language when their primary language is not English. Teams will arrange for interpreter services, as required by federal law.

28 ADMINISTRATIVE STANDARDS

28.1 Individual Records

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

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

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

28.4 Beneficiary treatment records shall be kept confidential and safe-guarded in a manner consistent with the requirements of the Health Insurance Portability and Accountability Act of

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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).

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

28.6 The active beneficiary record shall contain the following:

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

28.6.2 An up-to-date face sheet to include:

28.6.2.1 Date of admission;

28.6.2.2 Beneficiary address and contact information;

28.6.2.3 Photo of the beneficiary;

28.6.2.4 Date of birth;

28.6.2.5 MCI number;

28.6.2.6 Insurance;

28.6.2.7 Race, Ethnicity, Gender, Gender Identification;

28.6.2.8 Guardian, if appropriate, and contact information;

28.6.2.9 Emergency contacts and information;

28.6.2.10 Family/natural supports and contact information;

28.6.2.11 Allergies;

28.6.2.12 Diagnoses;

28.6.2.13 Treating Psychiatrist and contact information;

28.6.2.14 Primary Care Physician and contact information;

28.6.2.15 Existence of Advanced Directive and/or Psychiatric Advanced Directive.

28.6.3 Consent to treatment signed by the beneficiary;

28.6.4 Consent to any occasion of release of information;

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

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

28.6.7 Reports from all examinations, tests, and clinical consults;

28.6.8 Hospital discharge summaries;

28.6.9 Comprehensive medical psychosocial evaluation;

28.6.10 Comprehensive recovery plan development, review of recovery plan, and updates to recovery plan;

28.6.11 Crisis intervention plan and updates;

28.6.12 The beneficiary's Advance Directive or other documentation of measures to be taken in the event of incapacity;

28.6.13 Summary of monthly beneficiary activity;

28.6.14 Progress notes;

28.6.15 Documentation of case review with clinical supervisor;

28.6.16 Medication records;

28.6.17 Discharge documentation.

29 Performance Improvement Program

- 29.1 The 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:
- 29.1.1 A statement of the program's objectives. The objectives shall relate directly to the program's beneficiaries or target population.
 - 29.1.2 Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
 - 29.1.3 Methods for documenting achievements related to the program's stated objectives.
 - 29.1.4 Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
 - 29.1.5 In addition to the performance improvement and program evaluation plan, the 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.
 - 29.1.6 The ICM team shall maintain performance improvement and program evaluation policies and procedures that include:
 - 29.1.6.1 a concurrent utilization review process;
 - 29.1.6.2 a retrospective performance improvement review process;
 - 29.1.6.3 a process for clinical care evaluation studies; and
 - 29.1.6.4 process for self-survey for compliance with the certification standards and fidelity standards as prescribed by the Division.
- 29.2 The ICM team(s) shall ensure that data on the beneficiary's race, ethnicity, spoken and written language, sexual orientation, and gender expression are collected in health records, integrated into the organization's management information systems, and are periodically updated.
- 29.3 The ICM team(s) shall use the data outlined in 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.
- 29.4 Certified and/or Certified and Contracted Providers will be audited by Policy and Compliance audit teams.
- 29.4.1 Additional audit processes may be conducted by DSAMH contracts, fiscal, or Community Behavioral Health Bureau.
 - 29.4.2 If several deficiencies are found during Contract Review, this may affect the length of Certification.
- 29.5 An Administrative Appeal, requesting a formal change to an official decision regarding program certification, when a program is found in provisional status, may be made to the DSAMH Policy and Compliance within five (5) business days after the initial certification has been received.

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

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
295.10	295.90	Schizophrenia, Disorganized Type (<i>In DSM 5 Disorganized subtype no longer used</i>)	Psychotic Disorders ²
295.20	295.90	Schizophrenia, Catatonic Type (<i>In DSM 5 Catatonic subtype no longer used</i>)	Psychotic Disorders
295.30	295.90	Schizophrenia, Paranoid Type (<i>In DSM 5 Paranoid subtype no longer used</i>)	Psychotic Disorders
295.40	295.40	Schizophreniform Disorder	Psychotic Disorders
295.60	295.90	Schizophrenia, Residual Type (<i>In DSM 5 Residual subtype no longer used</i>)	Psychotic Disorders
295.70	295.70	Schizoaffective Disorder	Psychotic Disorders
295.90	295.90	Schizophrenia, Undifferentiated Type (<i>In DSM 5 Undifferentiated subtype no longer used</i>)	Psychotic Disorders
296.30	296.30	Major Depressive Disorder, Recurrent, Unspecified	Mood Disorders ³
296.32	296.32	Major Depressive Disorder, Recurrent, Moderate	Mood Disorders
296.33	296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features (<i>In DSM 5, “Without Psychotic Features” is not a further specifier</i>)	Mood Disorders
296.34	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features (<i>In DSM 5, “With psychotic features” is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁴	Mood Disorders
296.40	296.40	Bipolar I Disorder, Most Recent Episode Hypomanic ⁵	Mood Disorders
296.42	296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	Mood Disorders
296.43	296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features (<i>In DSM 5, “Without Psychotic Features” is not a further specifier</i>)	Mood Disorders

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

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

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

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

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DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
296.44	296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features (<i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁶	Mood Disorders
296.50	296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	Mood Disorders
296.52	296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	Mood Disorders
296.53	296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/o Psychotic Features (<i>In DSM 5, "Without Psychotic Features" is not a further specified</i>)	Mood Disorders
296.54	296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/ Psychotic Features (<i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁷	Mood Disorders
296.60		Bipolar I Disorder, Most Recent Episode Mixed, Unspecified (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.62		Bipolar I Disorder, Most Recent Episode Mixed, Moderate (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.63		Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.64		Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.70	296.70	Bipolar Disorder, Most Recent Episode Unspecified	Mood Disorders
296.89	296.89	Bipolar II Disorder	Mood Disorders
297.1	297.1	Delusional Disorder	Psychotic Disorders
301.0	301.0	Paranoid Personality Disorder	Personality Disorders
301.20	301.20	Schizoid Personality Disorder	Personality Disorders
301.22	301.22	Schizotypal Personality Disorder	Personality Disorders

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

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

Delaware State Standards for ICM 2021

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
301.83	301.83	Borderline Personality Disorder	Personality Disorders
309.81	309.81	Posttraumatic Stress Disorder (PTSD)	Anxiety Disorders ⁸

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

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

Functioning Criteria

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

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

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

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

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

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