



*Delaware Health
And Social Services*

DIVISION OF MANAGEMENT SERVICES

PROCUREMENT

DATE: January 18, 2012

HSS -11-098

ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE CASE MANAGEMENT SERVICES

for

Division of Substance Abuse and Mental Health

Date Due: 2/10/12

By 11:00 AM Local Time

ADDENDUM # 4

SECTION 1 – QUESTIONS AND ANSWERS

SECTION 2 – DHSS POLICY MEMORANDUM #37

SECTION 3 - DRAFT CERTIFICATION STANDARDS

SECTION 4 – ASAM INFORMATION

SECTION 1 – QUESTIONS AND ANSWERS

REQUEST FOR PROPOSAL No. HSS-11-098

Assertive Community Treatment and Intensive Case Management Services

Pre-Bid Meeting Audience Questions

January 17, 2012

1. Do we need to have participation in Minority or Women Owned Business?
No
2. Would everything have to be in house if we can't have subcontractors?
No other entity allowed.
3. Can we negotiate services in the community?
This is fine as long as they do not violate question #2.
4. If the person has no entitlements and they can't afford the co-pay will there be a sliding fee scale?
"Co-pays" will not be charged for uninsured clients utilizing the state pharmacy – not sure of the intent of the question. "Co-pays" usually relates to insurance coverages.
5. When you say Medicaid does that also include Medicare Part D?
Yes
6. What about Medicare Part D? The fee can't be waived.
With reference to the State pharmacy, Medicare Part D co-pays will also be charged in accordance with established procedures.
7. If they can't afford it, who is making that judgment? They can say everyone can't afford it and use the state pharmacy. How are they making that determination?
As stated at the pre-bid, clients with Medicaid benefits will have their choice of pharmacy services. Clients who are uninsured will be directed to the state pharmacy until they become eligible for benefits or for as long as they need. Co-payments cannot be paid by DSAMH going forward and co-pays will also be collected in the state pharmacy in accordance with established procedures.
8. What do you mean by sliding fee scale?
Please refer to DHSS Policy Memorandum #37 – the ability to pay contains a sliding fee scale

9. I'm confused, money DSAMH used to pay for co-pays is no longer available to CCCPs?
As stated at the pre-bid, clients with Medicaid benefits will have their choice of pharmacy services. Clients who are uninsured will be directed to the state pharmacy until they become eligible for benefits or for as long as they need. Co-payments cannot be paid by DSAMH going forward and co-pays will also be collected in the state pharmacy in accordance with established procedures.
10. What pharmacy do they use?
Not sure of the question.
11. Would you reimburse sliding scale co-pay?
No
12. There is other money tied to CCCP contracts not addressed in the RFP. Will they be broken out as other contracts (supported housing, supported employment)?
DSAMH will be working with each of the existing CCCP contracted vendors to address these issues. The funding will continue to exist for these purposes (i.e. housing and employment).
13. What about housing, group home, housing vouchers?
ACT/ICM clients are eligible for the same housing resources available to current CCCP clients, i.e. any that the individual is eligible for such as group homes, SRAP, HUD resources, etc.
14. Will the ACT/ICM members be able to access the CCCP housing resources, i.e. the 17 group homes, 9 supervised apartments, co-occurring residential treatment program? Yes.
15. Will the 650 housing subsidy vouchers mentioned in the DOJ settlement be made available? Yes, although the number of vouchers available for the ACT/ICM clients will vary by year and by overall demand for these vouchers.
16. Referring to the bottom of page 39, do you mean client assistance funds or flex funds?
Please disregard, correction will be posted
17. You don't want to see flex funds or any client assistance funds as part of the budget?
Correct, this has been deleted from the RFP.
18. Will client assistance money still be available?
Yes, we are in the process of determining the amount, allowable use and access procedures.

19. Where is the addendum to the RFP located for people not at the pre-bid meeting?
All changes will be posted on the website.
20. Do you have a plan in place for who would be responsible for fidelity plan, certification plan and monitoring?
The Quality Assurance and Performance Improvement team will be in charge of creating and monitoring program Certification and ongoing monitoring to ensure fidelity to the model
21. What can you provide about the reimbursement model?
We are currently working with a national consultant firm with extensive experience in designing ACT/ICM rate-setting methodologies. More information will be provided when it is determined which model we will be adopting.
22. What will the model be?
See #21
23. What portion of the population will be Medicaid vs. Medicare Part B?
This information is currently not available
24. How do you expect to bill for it?
See #21
25. Do you think you will have it before the close of the RFP?
Yes, DSAMH is hopeful that we will be able to provide the primary component and model of the methodology.
26. Are you trying to move away from clinics?
No, the clinic system will remain in place. Individuals will be assigned a level of care based on their need and preference.
27. Are you looking at already made clinics or are you looking at individual providers with teams?
We are looking for Fidelity based teams.
28. Could you clarify the relationship of these programs to CRISP and what you mean by incorporating CRISP elements?
Please disregard the CRISP reference – a correction will be posted
29. Do you really see these as independent programs?
Yes.
30. Would you accept telemedicine? Theoretically, we would accept it; however, DSAMH will need to fully understand the rationale for the use of Tele-Medicine and how it will fit into the team structure.

31. Can we use telemedicine for the psychiatrist services p. 13? Yes, see #30.
32. What about nurse practitioners? Do you allow them?
NP can be used, under supervision of a psychiatrist.
33. Billing model, telemedicine—are you bundling it?
We do not anticipate a bundled rate.
34. Is it OK to utilize the services of an APN instead of a psychiatrist for these services?
Yes, this is acceptable. See #35.
35. Will a waiver be needed?
The Certification Standard will state: *Psychiatric Prescriber*: A psychiatric prescriber may include:
- 7.1.1.1 A person with a Medical Degree or Doctor of Osteopathy degree, licensed to practice medicine in Delaware and who has completed (or is enrolled in) an accredited residency training program in psychiatry, internal medicine or family practice.
 - 7.1.1.2 A psychiatric nurse practitioner in psychiatric-mental health nursing who is licensed to practice medicine in Delaware or participates in the Nurse Licensure Compact (NLC.)
- 7.1.2 The psychiatric prescriber works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 consumers. The psychiatric prescriber provides clinical services to all ACT consumers; works with the team leader to monitor each consumer's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.
36. Will there be more than one provider in identified geographic location?
If yes, how will referrals be assigned? Contracts will be awarded per team so there may be multiple providers in a geographic location. Referrals will be made through the DSAMH Eligibility and Enrollment Unit (EEU).
37. If we're looking to be considered for more than one team do we need to submit more than one proposal?
No – please refer to pages 34 and 39 of the RFP for specific instructions
38. Can you send the DACT fidelity scale you will be using because I want us all to be submitting budgets that look similar and be clear about the rules?
Yes. It will be the Dartmouth model.

39. Please provide a link to DACTS fidelity scale and staffing requirements you will be using.
http://www.illinoismentalhealthcollaborative.com/provider/resources/ACT_instructions_4-16-08.pdf
40. Mix of ACT vs. ICM. You're asking us to propose which programs. Do you have a feel for population?
We cannot give an accurate account of this until we go through the process of reassessment and assignment. This reassessment and assignment will occur prior to the commencement of the new contracts.
41. Does the state pharmacy have the ability of billing all insurance providers currently?
It will have the capability when the contract begins.
42. You stated organizations didn't have to be non profit. Is this open to faith based organizations as well?
Yes, as long as they meet certification standards.
43. Where do you want us to delineate non-Dartmouth non-DACT staff?
We are not sure of the meaning of this question.
44. Are you expecting everybody except program assistance to be in that 12% overhead?
Please see #46.
45. Are you saying that if there's an administrator, business manager, you want these folks in the overhead? Will these costs fall under the 12% limited cap?
Please see #46
46. You are asking to have non-DACTS staff such as an administrator to be included in indirect or overhead costs. This will increase the usual overhead. Will you allow organizations to exceed the 12% guideline for indirect costs?
DHSS currently has a 12% cap for indirect costs – We are currently working with a national consultant to update our reimbursement methodology. All anticipated and approved costs will be part of the methodology.
47. The pharmacy clarification you made earlier...is there an amendment to the CRISP RFP as well? Please refer to website for CRISP RFP for specifics relating to that RFP.
48. The ASAM tool that's going to be used to assess potential members of the ACT team, will that be available during this period of time?
We will attach to the Q & A.

49. How will individuals pay co-pays to state run pharmacy when they do have zero income?
This will be done in accordance with established billing procedures.
50. Is Medicaid the same as Medicare D for purposes of where they can purchase medications?
Yes
51. Pharmacy, Section 5, p. 25: Medicare D gap coverage “donut hole”. Kevin said that the state will “have to pay for that”...please explain exactly what this means. Provide an example please.
As stated at the pre-bid meeting, clients with Medicaid/Medicare benefits will have their choice of pharmacy services. Clients who are uninsured will be directed to the state pharmacy until they become eligible for benefits or for as long as they need. Co-payments cannot be paid by DSAMH going forward and co-pays will also be collected in the state pharmacy according to established billing procedures.
52. Pharmacy, Section 5, p.25: Please provide a copy of financial used to determine if a person is able to ... (note: nothing further written on index card).
Question wasn't complete – unable to respond.
53. Will transition plans for existing programs be required?
The RFP requires applicants to submit a transition plan as part of the proposal.
54. The RFP states “the use of subcontractors will not be permitted.” Does this preclude the use of contract psychiatrists and nurses?
No.
55. The last paragraph on p.30 references Appendix H. There is no Appendix H?
Page 88 is Appendix H
56. What are the exact specifications for submission?
Please see RFP
57. What does printed and “bound” mean?
Three-ring binders, comb or wire binding – whichever you prefer
58. What is the preference for binding the printed copies? Three-ring binders? Comb or wire binding? Other?
No preference as long as it is bound
59. Any margin specs?
No.

60. Any font specs?
No.
61. Do you want each section to start on a separate page?
This is up to the proposer.
62. Do you want tabs?
This is up to the proposer
63. Do you want the business proposal bound separately?
The business proposal must be a separate component – it can be bound with the technical proposal as long it is clearly separate.
64. Can the quality improvement plan be an attachment?
This is up to the proposer
65. When you say sealed can it be sealed in a box?
As long as it is sealed and clearly identified as being in response to this RFP.
66. You said in the RFP that each team will have its own contract and budget.
Does that mean we need to submit a separate proposal for each team? No, as stated in the RFP, the proposal must contain a statement as to what you are applying for, how many teams, and what area you are requesting to provide services in. Separate budgets are required for ACT, ICM or combined teams – but only 1 for each type of program.
67. Can an agency serve as a rep payee?
No.
68. Once the state has worked out their preferred billing method, will the final payments/settlement with providers be based on that encounter billing (i.e. the contract payments will be based on that encounter/billing volume)?
It is anticipated that payments will incorporate both encounter billing and performance based payments.
69. Will any cost reporting be required?
Yes

70. On page 14, Scope of Service overview, the RFP states ‘the contractor is required to manage a program model that consists of a 100 person ACT team or a 100 person ICM team...The staffing composition must be based on the Dartmouth fidelity-based ACT model.’ The instrument that is used to measure ACT fidelity under the referenced model is the Dartmouth Assertive Community Treatment Scale (DACTS). The DACTS provides no provisions for caseload sizes of more than 10 clients/clinician. By definition, the proposed ICM and Mixed teams do not meet the highest level of DACTS fidelity. What set of standards for these teams is DSAMH proposing to use to measure fidelity?

For ACT, the “*TEAM*” size is to be no larger than 100 people per team. The “*CASE LOAD*” is to adhere to 1:10 as per DACTS. DSAMH will issue new standards based on DACTS. As the ICM and mixed model are not discussed under DACTS, DSAMH has adopted the following case load requirements within the overall DACT model: ICM 1:20; Mixed 1:15.

71. DACTS requires that a full-time psychiatrist be on the staff of a fidelity-based ACT team for every 100 clients. There are no provisions for this position to be filled by telemedicine or by a nurse practitioner, physician’s assistant or a physician who is not a psychiatrist in DACTS. At the pre-bid meeting it was suggested that a psychiatrist might not be required, but that a substitution of some other ‘psychiatric practitioner’ could be made. We do not believe that a team without a full time psychiatrist for every 100 service recipients would meet DACTS fidelity. Can you clarify DSAMH’s position on this?
Each ACT team must have a full time psychiatrist for every 100 consumers. Other psychiatric prescribers may fill in the team. Any team not able or intending to use a full time psychiatrist may submit a proposal with the plan to provide the required psychiatric services.

72. Our current CCCP contract contains the following non-ACT/ICM components:

Supportive Housing C-3	\$1,603,528.00
RMC Expansion funds Ford Ave. C-9	\$158,477.00
Oakfield Expansion C-10	\$166,980.27
Client Assistance and DPC discharge initiative	\$484,030.00
Successful Discharge incentive C-4	\$60,000.00
Supportive Employment C-5	\$66,000.00
RVRC Wilmington C-6	\$147,788.00
Dover Consumer Directed Program C-7	\$88,738.22

There is no mention of what will happen to these items and they are not included in what is being requested in the RFP. Can DSAMH clarify the Division's intentions relative to these current contract components?

We will work with each of the current CCCP providers on these other program components.

73. Is the bidder required to be a not-for profit organization, or are for profit organizations eligible to bid as long as they are not currently debarred or suspended, or otherwise ineligible to conduct business in the State of Delaware?
Yes, for profit organizations are eligible to bid.

74. (Page 38, N. Implementation Plan): What are the ramp-up expectations? To be faithful to the DACT model a full staff should be in place before the first consumer is enrolled in services. Are there start-up costs to pay for the highly specialized staffing requirements of an ACT or ICM or ACT/ICM team?
Given that the client population currently exists and will be transferred from the CCCP to the ACT/ICM teams, there will be very little time for ramp up. However, this can be negotiated with DSAMH. In addition, any request for start-up funds will be negotiated with successful providers

75. (Page 72, 13. Corporation Data): Can documents be California vs. Delaware with intentions to obtain Delaware documents once/if funded?
Yes

76. (Page 34, 2. Organizational Intent): Can "location" be defined in the context that the "Location of facility (facilities) must be identified."? Does this mean that the applicant would have to have a physical facility in place pre-bid?
No, however, the applicant is required to identify the coverage area(s) in which they are requesting to provide services.

77. How is this population currently being served?
They are currently served by the four Community Continuum of Care Programs (CCCP). These will no longer exist once this RFP process and subsequent contracting are complete.

78. What data management system is in place to manage the visits and data for the consumers?
This is currently being developed
79. What is the system for providers to bill Medicaid? If we are understanding the question, EDIS.
80. Are there specific staff that must be on the ACT or ICT team?
DACTS specifically outlines staffing and staff to consumer ratio.
81. How is the regions case load teams determined?
The EEU will continue to review and assign consumers.
82. How far would one team have to travel?
It is not DSAMH's intent to create teams that serve clients that live outside of a single County or a distance that is greater than the size of any of Delaware's Counties.
83. What are the reimbursed units and maximum units an individual can get as service per month?
This is currently being developed.
84. Is an office required in the region you are providing service?
This is not required but the respondent must address accessibility to all contracted services.
85. How many providers are currently providing housing? Are these providers able to provide ACT services?
There are currently five. Any of the current providers may bid for ACT/ICM services and if successful may continue to provide housing services as well.

CORRECTIONS TO THE RFP

Page 49 Item 3 Proposal Evaluation Criteria number 2: is deleted in its entirety and a new number 2 is substituted in lieu thereof to read; Proposed Program Design.

Page 39, Business Proposal Requirements: The last sentence "Client costs are to be identified on a separate worksheet." is hereby deleted.

SECTION 2 – DHSS POLICY MEMORANDUM #37

STATE OF DELAWARE
DELAWARE HEALTH AND SOCIAL SERVICES

POLICY MEMORANDUM NUMBER 37

February 1, 2009

SUBJECT: STANDARD ABILITY TO PAY FEE SCHEDULE (replaces February 1, 2008)

I. PURPOSE

To establish a uniform ability to pay schedule and to supplement existing collection policy or agreements to standardize Departmental collection efforts for recovery of accounts receivable that amount to less than the full cost of care due, in accordance with Delaware Code, Title 29, Section 7940.

II. DEFINITIONS

1. The "Cost of Services Rendered" in this policy shall mean the "Cost of Care" as used in Delaware Code, Title 29, Section 7940 and DHSS Policy Memorandum Number 12.
2. Disposable income for determination of ability to pay shall be gross income less a standard deduction and taxes paid.
3. Standard deduction shall be based on 100% of the poverty level.

III. EXCLUSIONS

This Policy Memorandum is not applicable to persons supported by Medicaid, Medicare, CHAMPUS, or private insurance with the exception of deductibles, coinsurance and charges for non-covered services of those payers who have contracts with DHSS facilities.

IV. FOREWORD

1. Respective Divisions shall continue to pursue recovery of the full cost of services rendered in accordance with the Department of Health and Social Services Policy Memorandum Number 12, as applicable.
2. Facilities should make every effort to assure that clients and legally liable persons are aware of and understand their fiscal liability, their right to request an adjustment to that liability, and the procedures to appeal the ability to pay determination.
3. Division Directors will develop procedures under the guidelines in Section VI for implementation of this policy within their respective Divisions.

V. PROCEDURES

A. INPATIENT SERVICES

The facility administration shall request, preferably before or, in case of emergency, after the patient is admitted or treated, a written agreement with those persons receiving or to receive care and/or treatment from the facility and, where appropriate, of the liable person(s) for the recovery of the full cost of care. (Appendix A) Liability of persons other than the patient shall be governed by the provisions of 29 Del. C. 7940 (a). The following procedures shall be implemented when a written agreement for the recovery of the full cost of services rendered cannot be obtained.

1. DHSS Ability to Pay Worksheet (Appendix B) should be completed for the person receiving care and for any other person liable under 29 Del. Code, 7940 (a), to determine disposable income and the minimum annual fee due based on the ability to pay. (Instructions on completion of the worksheet are on Attachment I "DHSS Ability to Pay Worksheet Instructions".)
2. The liability will automatically be waived for anyone with disposable income less than \$6,000.
3. The liable person shall be informed, in writing, of his/her liability, due dates of payment, and appeal procedures. (Appendix C).
4. All other payment agreements, in force prior to implementation of this Ability to Pay Fee Schedule, shall be gradually phased-out, for conformance, at the time of automatic review, which is at least every two (2) years. (Delaware Code, Title 29, Section 7940, Paragraph (d).

B. COMMUNITY-BASED & OUTPATIENT SERVICES

The Divisions shall determine the ability to pay of their clients for community-based and outpatient services and shall maintain a record of this information, which will be available at all service locations. The ability to pay will be determined, utilizing a sliding scale. The scale will be set using a range from 200% to 275% of the poverty level, with anyone whose gross income is at 200% or less of the poverty level, receiving the services free of charge. The percentage of charges to be paid will increase 20% for each 15% of the poverty level, the gross income increases with anyone whose gross income is above 260% of the poverty level paying 100% of the charge. The ability to pay sliding scale will be applied to the fees which are developed and implemented by the individual divisions of DHSS for each of the services they provide. The attached Table A shows the actual income levels to be used for family levels from 1 to 10.

TABLE A

Family Size % Poverty	Poverty Level	Annual Income Up To 200%	Annual Income Up To 215%	Annual Income Up To 230%	Annual Income Up To 245%	Annual Income Up To 260%	Annual Income Over 260%
1	\$10,830	\$21,660	\$23,285	\$24,909	\$26,534	\$28,158	\$28,158
2	14,570	29,140	31,326	33,511	35,697	37,882	37,882
3	18,310	36,620	39,367	42,113	44,860	47,606	47,606
4	22,050	44,100	47,408	50,715	54,023	57,330	57,330
5	25,790	51,580	55,449	59,317	63,186	67,054	67,054
6	29,530	59,060	63,490	67,919	72,349	76,778	76,778
7	33,270	66,540	71,531	76,521	81,512	86,502	86,502
8	37,010	74,020	79,572	85,123	90,675	96,226	96,226
9	40,750	81,500	87,613	93,725	99,838	105,950	105,950
10	44,490	88,980	95,654	102,327	109,001	115,674	115,674

% of Charge to be paid:

-0- 20% 40% 60% 80% 100%

Note: Federal guidelines related to specific programs take precedent over this policy

VI. ADMINISTRATIVE DETERMINATION

Division Directors are authorized to make administrative adjustments to the monthly fee calculated by the facility in lieu of submission to the Appeals Committee, if circumstances justify such adjustments. Administrative adjustment should be made only where the individual(s) have extraordinary expenses over which they have no control (i.e., medical bills, etc.). The procedures for administrative determination shall be as follows:

1. Division Directors should establish a Review Panel, consisting of three members: the Division Director or Deputy Director, an Institutional Representative and a Community-Based Representative.
2. Upon receipt of a written request appealing the ability to pay determination, the facility administration shall notify the individual that the appeal has been received and will forward the appeal request to the Division Director's office within five (5) working days for administrative review.
3. The Review Panel will meet no less than once a month to review the appeals received and make their determination.
4. The Review Panel shall notify the facility and the individual who is making the appeal concerning their determination within five (5) working days of the review.
5. If the Review Panel concurs with the original determination, the appeal will be forwarded to the Appeals Committee for final review.

VII. APPEALS

After implementation of Ability to Pay Fee Schedule, any person aggrieved by any decision with respect to the payment of fees, refusal of admission or discharge for other than medical reasons, may appeal by petition to the Appeals Committee in writing, stating the substance of the decision appealed, the facts in support of the appeal and the relief sought.

The Appeals Committee consist of the Chairpersons of the:

- o Advisory Council on Developmental Disabilities Services;
- o Advisory Council on Substance Abuse and Mental Health;
- o Advisory Council for Delaware Hospital f/t Chronically Ill;
- o Public (Physical) Health Advisory Council.

1. The Appeals Committee shall hold a hearing within sixty (60) days and shall render its decision promptly. The Committee's decision shall be final and binding.
2. The Secretary's Office will receive the appeal information, schedule the hearing and notify the Appeals Committee and the individual appealing of the date and location of the hearing.
3. The appeals hearings will be chaired on a rotating basis with each member of the committee serving as chairperson for a period of three (3) months.

VIII. COLLECTION

Collection efforts and write-off procedures shall be in conformance with DHSS Policy Memorandum Number 19.

IX. ADMINISTRATION

An Ability to Pay Committee shall be available to help resolve implementation/interpretation problems. It will set up such rules and regulations as are deemed necessary, pursuant to the authority granted by 29 Del. C. 7940 (j).

1. A permanent committee shall be assigned to monitor and administer the Ability to Pay Fee Schedule.
2. The Ability to Pay Committee shall consist of:
 - (a) Two representatives each from the Divisions of Substance Abuse and Mental Health; Developmental Disabilities Services; and Public Health;
 - (b) One representative from the Division of Management Services, who shall serve as Chairman.

X. EFFECT

1. This policy shall become effective on February 1, 2009.
2. Any part thereof which is inconsistent with any Federal, State or local law shall be null and void.

Landgraf

Rita

Rita M. Landgraf
Secretary
Department of Health & Social Services

Attachment

POLICY MEMORANDUM NUMBER 37
February 1, 2009
Page Six

APPENDIX A
LETTERHEAD

Patient Name _____

Date: _____

Dear _____,

This is to advise you that the charge for services rendered at (facility) is \$ _____ per day. The patient and/or any persons legally liable under Title 29, Section 7940 of the Delaware Code will be billed for these services.

Please complete and return this form
to _____ by _____
Financial Services Rep. (Date)

Check if Applicable:

___ 1. I have the following insurance coverage, which should be billed:

- Blue Cross
- Medicare
- Other Insurance
- Medicaid

Group # _____ Policy # _____
Name of Person Insured _____

___ 2. I will make full payment as billed.

___ 3. I am unable to pay the full amount.

Date _____ Signature _____

If #3 is checked, please submit the following information for our review to determine an appropriate payment based on your ability to pay.

1. A copy of your most recent Federal and State Income Tax returns.
2. A copy of all W-2 Forms submitted with your tax returns.
3. Other documents which show your current income.

You will be notified in writing of our determination. We will be unable to make any adjustments to the amount, which you are required to pay if the information is not submitted.

Thank you for your cooperation.

Sincerely,

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APPENDIX B

PATIENT NAME:

DATE:

ADDRESS:

GUARANTOR NAME:

ADMISSION DATE:

ADDRESS:

INSURANCE COVERAGE:

PREPARED BY: _____

APPROVED BY: _____

1. GROSS INCOME

\$ _____

LESS:

2. STANDARD DEDUCTION _____

3. TAXES WITHHELD

FICA _____

FEDERAL INCOME _____

STATE INCOME _____

CITY WAGE _____

4. TAX (REFUNDS)/PAYMENTS _____

5. TOTAL DEDUCTIONS (SUM OF LINES 2-4)

\$ _____

6. DISPOSABLE INCOME (LINE 1 LESS LINE 5)

\$ _____

7. MAXIMUM ANNUAL FEE DUE BASED ON ABILITY TO PAY. (10% OF LINE 6)

\$ _____

8. MONTHLY PAYMENT. (LINE 7 DIVIDED BY 12)

\$ _____

POLICY MEMORANDUM NUMBER 37

February 1, 2009

Page Eight

DHSS
ABILITY TO PAY WORKSHEET
INSTRUCTIONS

LINE 1. Gross income is obtained from a copy of the Tax Return, if one was filed, or from a copy of other payment sources (if non-taxable, such as Welfare payments, Pension payments, or other income).

LINE 2. Standard Deduction is shown below, (for families with more than 8 persons, add \$3,740 for each additional person).

Household Size	Amount	Household Size	Amount
1	\$10,830	6	29,530
2	14,570	7	33,270
3	18,310	8	37,010
4	22,050	9	40,750
5	25,790	10	44,490

LINE 3: Taxes withheld are obtained from a copy of W-2 forms.

LINE 4: Amount of tax refunds or payments are from Federal and State tax returns.

LINE 5: Total deductions equal the sum of Lines 2 through 4.

LINE 6: Disposable income is Gross income (Line 1) less total deductions (Line 5).

LINE 7: Maximum annual fee is 10% of disposable income (Line 6 X .1). (The maximum annual fee will be automatically waived if disposable income is less than \$6,000.)

LINE 8: Monthly payment = Annual payment (Line 7) divided by 12.

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February 1, 2009
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APPENDIX C

LETTERHEAD

NAME:

DATE:

ADDRESS:

PATIENT NAME:

DEAR _____:

We have reviewed the information which you supplied and have calculated your minimum monthly payment according to Delaware Law 29 Del. C. 7940 and Department of Health and Social Services Policy Memorandum Number 37. You are responsible for a monthly payment of \$_____ for the services rendered to the above named patient. A copy of our calculation has been enclosed for your benefit. Payments are due by the 20th of the month for the previous month's care.

You have the right to appeal the determination, in writing, to the Appeals Committee stating the substance of the decision being appealed, the facts in support of the appeal, and the relief sought.

Appeals should be submitted to:

Appeals Committee Administrator

_____ (Facility Name)

_____ (Facility Address)

Thank you for your cooperation in this matter.

Sincerely,

SECTION 3 – DRAFT CERTIFICATION STANDARDS

PROVIDER CERTIFICATION MANUAL
FOR
COMMUNITY SUPPORT SERVICES PROGRAMS

Assertive Community Treatment
Intensive Care Management

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

OVERVIEW

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

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

The Delaware Medical Assistance Program covers optional behavioral health rehabilitative services provided to eligible Medicaid recipients by certified providers. Behavioral Health rehabilitative services are medically related treatment, rehabilitative and support services for persons with disabilities caused by mental illness, and substance use disorders. The Community Continuum of Care Program (CCCP), Psychosocial Rehabilitation Center (PRC) and Residential Rehabilitation Facility (RRF) are categories of community support programs that the Division certifies for Medicaid provider enrollment. Services are provided for as long as medically necessary to assist service recipients to cope with the symptoms of their illnesses, minimize the effects of their disabilities on their capacity for independent living and prevent or limit periods of inpatient treatment.

1 CERTIFICATION FOR PROVIDER PARTICIPATION

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

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

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

1.2.1.1 Private non-profit human service corporations;

1.2.1.2 Private for-profit human service corporations;

1.2.1.3 State, county or municipal government-operated health and human services departments.

1.2.2 The Division bases its certification of programs and enrollment recommendation to DHSS upon the organization's compliance with state level organizational, administrative and program standards and with federal requirements for the administration of Medicaid services as contained in federal statutes, regulations and guidelines.

1.2.2.1 The Division may establish and apply minimum compliance guidelines to be used in making certification determinations.

1.2.3 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:

1.2.3.1 Statements of the organization's authorized representatives;

1.2.3.2 Documents provided to the Division by the organization; 1.2.3.3 Documented compliance with organizational, program and administrative standards;

1.2.3.4 On-site observations by surveyor.

2 Definitions

Assertive Community Treatment (ACT) is a self-contained mental health program made up of transdisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. ACT services are individually tailored with each consumer through relationship building, individualized assessment and planning, and active involvement with consumers to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, and to achieve individual goals, and to maintain optimism and recover. The ACT team is mobile and delivers services in community locations rather than expecting the consumer to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for consumers. The consumers served have severe and persistent mental illness that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. There should be no more than 10 consumers to one staff member on each team.

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

Clinical Supervision is a systematic process to review each consumer's clinical status and to ensure that the individualized services and interventions that the team members provide (including the peer specialist) are planned with, purposeful for, effective, and satisfactory to the consumer. The team leader and the psychiatric prescriber have the responsibility to provide clinical supervision which occurs during daily organizational staff meetings, recovery planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, recovery plans, progress notes, correspondence).

Comprehensive Assessment is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from

dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the consumer 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 consumer; 2) set goals and develop the first person-centered recovery plan with each consumer; and 3) optimize benefit that can be derived from existing strengths and resources of the individual and his/her family and/or natural support network in the community.

Consumer is a person who has agreed to receive services and is receiving person-centered treatment, rehabilitation, and support services from the ACT team.

Co-Occurring Disorders Services include integrated assessment and treatment for individuals who have a co-occurring mental health and substance use disorder.

Crisis Assessment and Intervention includes services offered 24 hours per day, seven days per week for consumers when they are experiencing crisis.

Daily Log is hand written or computerized form which the ACT team maintains on a daily basis to provide: 1) a roster of consumers served in the program; and 2) for each consumer, a brief documentation of any treatment or service contacts which have occurred during the day and a concise behavioral description of the consumer's clinical status and any additional needs.

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

Daily Staff Assignment Schedule is a written, daily timetable summarizing all consumer 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 consumer schedules.

Family and Natural Supports' Psychoeducation and Support is an approach to working in

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

Individual Treatment Team (ITT) is a group or combination of three to five ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the team leader and the psychiatric prescriber to work collaboratively with a consumer and his/her family and/or natural supports in the community by the time of the first person-centered recovery planning meeting or thirty days after admission. The core members are the primary practitioner, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each consumer. The ITT has continuous responsibility to be knowledgeable about the consumer's life, circumstances, goals and desires; to collaborate with the consumer 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 consumer's needs change; and to advocate for the consumer's wishes, rights, and preferences. The ITT is responsible to provide much of the consumer's treatment, rehabilitation, and support services. ITT members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the recovery plan.

Individual Therapy includes verbal therapies that help people make changes in their feelings, thoughts, and behavior in order to move toward recovery, clarify goals, and address stigma. Supportive therapy and psychotherapy also help consumers understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and evaluate treatment and rehabilitative services.

Initial Assessment and Person-Centered Recovery plan is the initial evaluation of: 1) the consumer's mental and functional status; 2) the effectiveness of past treatment; 3) the current treatment, and rehabilitation and support service needs, and 4) the range of individual strengths that can act as resources to the person and his/her ITT 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 consumer's initial assessment and recovery plan guides team services until the comprehensive assessment and full person-centered recovery plan is completed.

Medication Assistance is the oversight of medication adherence where a member of the ITT observes self administration of medication. ITT members must receive Assistance With Self Administered Medication (AWSAM) training at the beginning of employment and annually

thereafter. No ITT member may observe medication administration prior to initial AWSAM training.

Medication Distribution is the physical act of giving medication to consumers in a ACT program by the prescribed route which is consistent with state law and the licenses of the professionals privileged to prescribe and/or administer medication (e.g., psychiatric prescribers, registered nurses, and pharmacists).

Medication Error is any error in prescribing or administering 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 consumer and the psychiatric prescriber with the participation of the ITT to carefully evaluate the consumer'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 according to evidence-based practice standards.

ACT Primary Practitioner leads and coordinates the activities of the individual treatment team (ITT) and is the ITT member who has primary responsibility for establishing and maintaining a therapeutic relationship with a consumer on a continuing basis, whether the consumer 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 consumer's life, circumstances, and goals and desires. The primary practitioner develops and collaborates with the consumer to write the person-centered recovery plan, offers options and choices in the recovery plan, ensures that immediate changes are made as the consumer's needs change, and advocates for the consumer's wishes, rights, and preferences. The primary practitioner also works with other community resources, including consumer-run services, to coordinate activities and integrate other agency or service activities into the overall service plan with the consumer. The primary practitioner provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people. In most cases the primary practitioner is the first ITT member available to the consumer in crisis. The primary practitioner shares these service activities with other members of the ITT who are responsible to perform them when the primary practitioner is not working.

Peer Support and Wellness Recovery Services include services which serve to validate

consumers' experiences, provide guidance and encouragement to consumers to take responsibility for and actively participate in their own recovery, and help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce consumers' self-imposed stigma. Such services also include *counseling* and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness.

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

Psychiatric and Social Functioning History Time Line is a format or system which helps ACT staff to organize chronologically information about significant events in a consumer's life, experience with mental illness, and treatment history. This format allows staff to more systematically analyze and evaluate the information with the consumer, to formulate hypotheses for treatment with the consumer, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer.

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

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

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

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

Symptom Management is an approach directed to help each consumer identify and target the symptoms and occurrences of his or her mental illness and develop methods to help reduce the impact of those symptoms.

Transdisciplinary Approach specifies that team members share roles and systematically cross discipline boundaries. The primary purpose of this approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give and-take among all members (inclusive of the consumer and, if desired, his/her family/other natural supports) on a regular, planned basis. The role differentiation between disciplines is defined by the needs of the situation rather than by discipline-specific characteristics. The transdisciplinary approach can be contrasted with the multidisciplinary approach in which team members independently carry out assessments and implement their own section of the treatment plan, rather than in a cross-disciplinary, integrated fashion, which also serves to actively involve the consumer in their own assessment and treatment.

Recovery plan Review is a thorough, written summary describing the consumer's and the ITT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered recovery plan.

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

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

Weekly Consumer Contact Schedule is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given consumer's person-centered recovery plan. The ITT shall maintain an up-to-date weekly consumer contact schedule for each consumer per the person-centered recovery plan.

Wellness Management and Recovery Services are a combination of psychosocial approaches to working with the consumer 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, and getting needs met within the mental health system and community.

3.0 Admission and Discharge Criteria

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

3.1.2 Severe and persistent mental illness listed in the most recent Diagnostic and Statistical Manual (DSM) that seriously impairs a consumer's functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals must have a primary mental health diagnosis or COD diagnosis. Individuals with a sole diagnosis of a substance use disorder, mental retardation, brain injury or Axis II disorders are not the intended consumer group for ACT services. Individuals who have not been able to remain abstinent from drugs or alcohol will not be excluded from ACT services.

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

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

3.1.3.2 Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).

3.1.3.3 Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

3.1.3.4 Continuous high-service needs as demonstrated by at least one of the following:

3.1.3.4.1 High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.

3.1.3.4.2 Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).

3.1.3.4.3 Co-occurring substance use disorder of significant duration (e.g., greater than six months).

3.1.3.4.4 High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).

3.1.3.4.5 Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at imminent risk of becoming homeless.

3.1.3.4.6 Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.

3.1.3.4.7 Difficulty effectively utilizing traditional office-based outpatient services or other less-intensive community-based programs (e.g., consumer fails to progress, drops out of service).

3.1.3.5 Documentation of admission shall include:

3.1.3.5.1 The reasons for admission as stated by both the consumer and the ACT team.

3.1.3.5.2 The signature of the psychiatric prescriber.

3.1.4 The Division 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 DSAMH to be supported by the assessment materials.

3.1.5 Determination of consumer eligibility for Medicaid benefits is the sole responsibility of DHSS.

3.2 The CCCP shall notify DSAMH a minimum of fourteen (14) days prior to the tentative discharge date of any consumer being considered for discharge by ACT Team.

3.2.3 The CCCP shall consult and cooperate with DSAMH in the development and implementation of a mutually agreed upon consumer retention plan when retention is deemed by DSAMH as preferable to discharge.

3.2.4 The CCCP shall consult and cooperate with DSAMH in the development and implementation of a mutually agreed upon discharge plan, including referral/transfer to appropriate post-discharge services.

3.2.5 The termination of services shall occur when consumers:

3.2.5.1 Have successfully reached individually established goals for discharge and when the consumer and program staff mutually

agree to the termination of services.

3.2.5.2 Move outside the geographic area of ACT's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to a ACT program or another provider wherever the consumer is moving. The ACT team shall maintain contact with the consumer until this service transfer is completed.

3.2.5.3 Demonstrate an ability to function in all major role areas (i.e., work, social, selfcare) without requiring ongoing assistance from the program for at least one year without significant relapse when services are withdrawn.

3.2.5.4 Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable person-centered recovery plan with the consumer.

3.2.6 In addition to the discharge criteria listed above based on mutual agreement between the consumer, ACT staff and DSAMH, a consumer discharge may also be facilitated due to any one of the following circumstances:

3.2.6.1 Death.

3.2.6.2 Inability to locate the consumer for a prolonged period of time.

3.2.6.3 Long-term incarceration.

3.2.6.4 Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the ACT team that the consumer will not be appropriate for discharge for a prolonged period of time.

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

3.2.7.1 The discharge summary shall include:

3.2.7.1.1 Date of discharge;

3.2.7.1.2 Reason for discharge;

3.2.7.1.3 Consumers status upon discharge based on the most recent Biopsychosocial ;

3.2.7.1.4 Multiaxial DSM diagnosis;

- 3.2.7.1.5 Summary of progress toward meeting goals as set forth in the client centered recovery plan;
- 3.2.7.1.6 Aftercare/follow-up plan completed in conjunction with the consumer;
- 3.2.7.1.7 The consumer's forwarding address and/or telephone number.

3.2.8 The discharge summary shall be:

3.2.8.1 Completed within 5 days of discharge from the CCCP.

3.2.8.2 Signed and dated by:

- 3.2.8.2.1 The consumer when the discharged is planned
- 3.2.8.2.2 The case manager;
- 3.2.8.2.3 The physician;
- 3.2.8.2.4 The Team Leader.

4 Service Intensity and Capacity

4.1 Staff-to-Consumer Ratio:

- 4.1.1 Each ACT team shall have the organizational capacity to provide a minimum staff-to consumer ratio of at least one full-time equivalent (FTE) staff person for every 10 consumers (not including the psychiatric prescriber and the program assistant) per team.
- 4.1.2 Each ICM team shall have the organizational capacity to provide a minimum staff to consumer tation of at least one full-time equivalent (FTE) staff p erson for every 20 consumers (not including the psychiatric presciber and the program assistant) per team.
 - 4.1.2.1 Programs **MUST** have distinct ACT and ICM teams. When integrating ACT and ICM teams, the number of integrated teams shall not exceed one (1) team per program.
- 4.1.3 The maximum number of consumers being served by any one ACT team is 80 - 100. Teams of 100 or more may break into two teams.
- 4.1.4 The maximum nuber of consumers being served by any one ICM team is 150-200. Teams of 150 or more may break into two teams.

4.2 Staff Coverage

4.2.1 Each ACT and ICM team shall have sufficient numbers of staff to provide treatment, rehabilitation, crisis intervention and support services 24 hours a day, seven days per week.

4.3 Frequency of Consumer Contact

4.3.1 The ACT team shall have the capacity to provide multiple contacts per week with consumers experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on consumer need and a mutually agreed upon plan between consumers and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all consumers requiring frequent contact.

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

4.3.3 The following services as deemed necessary by assessment and prescribed by the individual recovery plan will be provided:

4.3.4 Psychiatric and substance abuse treatment;

4.3.4.1 Psychiatrist: Face-to-face evaluation a minimum of every 14 days for the first 90 days of treatment and then every 30 days thereafter.

4.3.4.2 Medication monitoring as follows:

4.3.4.2.1 The psychiatrist will explain to the consumer the rationale for each medication prescribed as well as the medication's risks/benefits.

- 4.3.4.2.2 Informed consent shall be obtained for each medication prescribed at the time it is prescribed.
- 4.3.4.2.3 Informed consent shall be updated, at a minimum, annually.
- 4.3.4.2.4 Rationale for all changes in medication orders shall be documented in the physician's note.
- 4.3.4.2.5 All medication orders in the consumer's case record shall specify:
 - 4.3.4.2.5.1 Name of the medication;
 - 4.3.4.2.5.2 Dosage;
 - 4.3.4.2.5.3 Route of administration;
 - 4.3.4.2.5.4 Frequency of administration;
 - 4.3.4.2.5.5 Signature of the physician prescribing the medication;
 - 4.3.4.2.5.6 All known drug allergies.
- 4.3.4.2.6 Administration of medication by any method and/or the supervision of consumers in the self-administration of medication must be conducted and documented in conformance with the program's written policies and procedures for medication management.
 - 4.3.4.2.6.1 Medication administration records shall contain the following:
 - 4.3.4.2.6.1.1 Name of the medication;
 - 4.3.4.2.6.1.2 Dosage;
 - 4.3.4.2.6.1.3 Route of administration;
 - 4.3.4.2.6.1.4 Frequency of administration;
 - 4.3.4.2.6.1.5 All known drug allergies;
 - 4.3.4.2.6.1.6 Name of the person administering or assisting with the administration of medication.
 - 4.3.4.2.6.1.7 Signature of the person administering or assisting with the administration of medication.
 - 4.3.4.2.6.2 Staff shall monitor and document consumer adherence to following the prescribed medication treatment and the medication side effects to include the following:
 - 4.3.4.2.6.2.1 Laboratory studies for all medications which require laboratory monitoring as recommended in the current Physician's Desk Reference;
 - 4.3.4.2.6.2.1.1 Laboratory reports shall:

4.3.4.2.6.2.1.1.1 be reviewed and signed by the Physician or Registered Nurse within two (2) days of receipt.

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

4.3.4.2.6.2.3 AIMS (Abnormal Involuntary Movement Scale) shall be performed no less than annually to assess clients at risk for developing Tardive Dyskinesia.

4.3.4.2.6.2.4 Education of clients regarding side effects of prescribed psychotropic medications.

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

5 Staff Requirements

5.1 Qualifications

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

5.1.1.1 Service coordination;

5.1.1.2 crisis assessment and intervention;

5.1.1.3 recovery and symptom management;

5.1.1.4 individual counseling and psychotherapy;

5.1.1.5 medication prescription, administration, monitoring and documentation;

5.1.1.6 substance abuse treatment;

5.1.1.7 work-related services;

5.1.1.8 activities of daily living services;

5.1.1.9 social, interpersonal relationship and leisure-time activity services;

5.1.1.10 support services or direct assistance to ensure that consumers obtain the basic necessities of daily life;

5.1.1.11 and education, support, and consultation to consumers' families and other major supports.

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

6 Team Size

6.1 The program shall employ a minimum of 10 to 12 FTE transdisciplinary clinical staff persons, including 1 FTE team leader and 1 FTE peer specialist on the team.

6.2 Mental Health Professionals on Staff

6.2.1 Of the minimum 10 to 12 FTE transdisciplinary clinical staff positions on an ACT team, there are a minimum of 8 FTE mental health professionals (including one FTE team leader).

6.2.1.1 Mental health professionals have:

- 6.2.1.1.1 professional degrees in one of the core mental health disciplines;
- 6.2.1.1.2 clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting;
- 6.2.1.1.3 clinical work experience with persons with severe and persistent mental illness.

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

6.2.2.1 persons with master's or doctoral degrees in:

- 6.2.2.1.1 nursing,
- 6.2.2.1.2 social work,
- 6.2.2.1.3 rehabilitation counseling,
- 6.2.2.1.4 psychology;
- 6.2.2.1.5 diploma, associate, and bachelor's nurses (i.e., registered nurse);
- 6.2.2.1.6 and registered occupational therapists.

6.2.3 Required among the mental health professionals are:

- 6.2.3.1 A minimum of 3 FTE and a maximum of 5 FTE registered nurses (a team leader with a nursing degree cannot replace one of these FTE nurses).
- 6.2.3.2 A minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader).

7 Required Staff

7.1 The chart below shows the required staff:

Position	Requirements
Team leader	1 FTE
Psychiatric prescriber	16-Hours for 50 Consumers
Registered Nurse	3 - 5 FTE
Peer Specialist	1 FTE
Master's level*	4 FTE
Other level*	1 - 3 FTE
Program/Administrative Assistant	1-1.5 FTE
Chemical Dependency Specialist (CADC or national equivalent)	1 FTE
Vocational Rehabilitation Specialist	1 FTE

7.2 Vocational Specialist and 1 FTE Chemical Dependency Specialist may be included within either the "Master's level" or "Other level" staffing categories above.

7.3 The following provides a description of and qualifications for required staff on all ACT teams:

7.3.1 **Team Leader:** A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACT team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatric prescriber.

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

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

- 7.3.2.2 A psychiatric nurse practitioner in psychiatric-mental health nursing who is licensed to practice medicine in Delaware or participates in the Nurse Licensure Compact (NLC.)
- 7.3.3 The psychiatric prescriber works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 consumers. The psychiatric prescriber provides clinical services to all ACT consumers; works with the team leader to monitor each consumer's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.
- 7.3.4 **Registered Nurses:** All registered nurses shall be licensed in the State of Delaware or participating in the NLC. A minimum of 3 FTE and a maximum of 5 FTE registered nurses are required.
- 7.3.5 **Master's Level Mental Health Professionals:** A minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) are required on the ACT team.
- 7.3.6 **Chemical Dependency Specialist:** One or more team members must be Chemical Dependency Specialist with:
- 7.3.6.1 Certification in the state of Delaware as a Certified Alcohol and Drug Counselor (CADC) or Certified Co-occurring Disorder Counselor (CCDC); OR
 - 7.3.6.2 at least 3 years of supervised experience and 40 hours of training specific to substance abuse assessment and treatment.
- 7.3.7 **Vocational Specialist:** One or more team members with training and experience in vocational services shall be designated the role of vocational specialist, with preference given to a master's degree in rehabilitation counseling or at least one year of experience in employment services (e.g., job development, job placement, supported employment).
- 7.3.8 **Peer Specialist:** A minimum of one FTE peer specialist is required on an ACT team. Because of their life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote consumer self-determination and

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

7.3.9 *Remaining Clinical Staff:* The remaining clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions.

7.3.9.1 A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness.

7.3.9.2 A paraprofessional mental health worker may have:

7.3.9.2.1 a bachelor's degree in a field other than behavioral sciences; or

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

8 *Policy and Procedure Requirements:*

8.1 The Community Support Services program shall maintain a written procedure manual for its staff. A mechanism shall be in place to ensure that the procedure manual is updated continuously and that the staff of the program is notified promptly of changes. The manual shall include:

8.1.1.1 A statement of the program's values, mission and objectives;

8.1.1.2 Referral policies and procedures that facilitate consumer referral;

8.1.1.3 Detailed instructions for assessment, recovery planning and documentation procedures;

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

- 8.1.1.4.1 Prescribing medication;
- 8.1.1.4.2 Storage of medication;
- 8.1.1.4.3 Handling of medication;
- 8.1.1.4.4 Distribution of medication;
- 8.1.1.4.5 Dispensing of medication;
- 8.1.1.4.6 Disposing of medication;
- 8.1.1.4.7 Recording of medication used by consumers.
- 8.1.1.5 Policies and procedures for handling on-call responsibilities and consumer emergencies;
- 8.1.1.6 Detailed instructions for application to and communication with entitlement authorities;
- 8.1.1.7 Policies and procedures for sharing of information about consumers with family members or others;
- 8.1.1.8 Policies and procedures regarding commteaming and handling financial resources of the program;
- 8.1.1.9 Policies and procedures regarding the management of consumer's funds for whom the program has been designated payee;
- 8.1.1.10 Policies and procedures for the receipt, consideration and resolution of consumer complaints and/or grievances regarding treatment decisions and practices or other program activities.
- 8.1.1.11 Other policies and procedures as maybe promulgated or required by the Division of Substance Abuse and Mental Health.

8.1.2 Personnel Management

- 8.1.2.1 The CCCP or parent organization 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:
 - 8.1.2.1.1 Policies and procedures regarding equal employment opportunity and affirmative action to include compliance with:
 - 8.1.2.1.2 The Americans with Disabilities Act and the Vocational Rehabilitation Act of 1973, Sections 503 and 504 prohibiting discrimination against the handicapped;
 - 8.1.2.1.3 Title VII of the Civil Rights Act of 1964 prohibiting discrimination on the basis of race, color, creed, sex or national origin;
 - 8.1.2.1.4 Title XIX of Del section 711 prohibiting discrimination on the basis of race, color, creed, sex, sexual orientation and national origin;

- 8.1.2.1.5 Age discrimination Act of 1975 prohibiting discrimination based on age;
- 8.1.2.1.6 Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974 prohibiting discrimination against disabled Vietnam Era veterans.
- 8.1.2.2 Policies and procedures for interviews and selection of candidates including verification of credentials and references;
- 8.1.2.3 Policies and procedures for employee performance appraisal;
- 8.1.2.4 A code of ethics;
- 8.1.2.5 Conditions and procedures for termination of employment;
- 8.1.2.6 Conditions and procedures for grievances and appeals;
- 8.1.2.7 An annual staff development plan which shall include:
 - 8.1.2.7.1 Provisions for orientation of paid staff, student interns and volunteers. Orientation shall include:
 - 8.1.2.7.1.1 Review of these standards;
 - 8.1.2.7.1.2 Review of the program's procedures and personnel manuals;
 - 8.1.2.7.1.3 Review of DHSS Policy Memorandum #46;
 - 8.1.2.7.1.4 Review of section 5161 of Title 16;
 - 8.1.2.7.1.5 Review of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164;
 - 8.1.2.7.1.6 Review of 42 C.F.R. Part 2.
 - 8.1.2.7.2 Provisions for continuing education of staff;
 - 8.1.2.7.3 Provisions for regularly scheduled clinical supervision which teach and enhance the clinical skills of staff including:
 - 8.1.2.7.3.1 Weekly team meetings led by the clinical supervisor during which assessments, recovery plans and progress toward treatment goals are reviewed and staff receive direction regarding clinical management of treatment issues.
 - 8.1.2.7.3.2 Individual face-to-face sessions between the clinical supervisor and staff to review cases, assess performance and give feedback;
 - 8.1.2.7.3.3 Individual, side-by-side sessions during which the clinical supervisor attends clinical sessions conducted by staff to assess performance, teach clinical skills and give

feedback.

8.1.2.8 Maintenance and access to personnel files which shall contain employees' applications, credentials, job descriptions, and performance appraisals, job titles, training, orientation, salary, staff statement of confidentiality.

8.1.2.9 Work hours including hours of program operation, shifts and overtime compensation.

8.1.2.10 Agency policies regarding compensation including:

8.1.2.10.1 salary ranges, salary increases, and payroll procedures;

8.1.2.10.2 Use of personal automobile for program activities;

8.1.2.10.3 Reimbursement for work-related expenses;

8.1.2.10.4 Description of employee benefits.

9 Hours of Operation and Staff Coverage

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

9.1.1 Regularly operating and scheduling staff to work two eight-hour shifts with a minimum of 2 staff on the second shift providing services at least 12 hours per day weekdays.

9.1.2 Regularly operating and scheduling ACT staff to work one eight hour shift with a minimum of 2 staff each weekend day and every holiday.

9.1.3 Regularly scheduling ACT staff on-call duty to provide crisis services and deliver services the hours when staff is not working.

9.1.4 Mental Health Professionals on the ACT staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call to provide back-up to on-call staff and be available to respond to consumers by telephone or by going out to see consumers who need face-to-face contact.

9.1.5 Regularly arranging for and providing psychiatric backup all hours the psychiatric prescriber is not regularly scheduled to work. If availability of the ACT psychiatric prescriber during all hours is not feasible, alternative psychiatric backup should be

arranged (e.g., mental health center psychiatric prescriber, emergency room psychiatric prescriber).

9.1.6 Through the use of the *Daily Organizational Staff Meeting* and the *Daily Staff Assignment Schedule*, adjusting schedules and providing staff to carry out the needed service activities in the evenings or on weekend days when necessary;

9.1.7 Regularly scheduling staff on-call duty to provide crisis services and deliver services the hours when staff is not working. ACT team staff who are experienced in the program and skilled in crisis intervention procedures shall be on call and available to respond to consumers by telephone or in person.

9.1.8 The ACT team shall rotate cell phone/pager coverage 24/7 to be available for face-to-face contacts and shall arrange with the crisis intervention service to be notified when a face-to-face contact is needed.

10 Place of Treatment

10.1 Seventy-five percent (75%) of service contacts shall be provided in nonoffice-based or nonfacility-based settings. The program will collect data regarding the percentage of consumer contacts in the community as part of its Quality Improvement (QI) Plan and report this data to DSAMH upon request.

11 Staff Communication and Planning

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

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

11.1.1.1 A roster of the consumers served in the program, and for each consumer,

- 11.1.1.1.1 a brief documentation of any treatment or service contacts that have occurred during the last 24 hours
 - 11.1.1.1.2 a concise, behavioral description of the consumer's status that day.
- 11.1.2 The daily organizational staff meeting shall commence with a review of the daily log to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all consumers.
- 11.1.3 The ACT team, under the direction of the team leader, shall maintain a weekly consumer contact schedule for each consumer. The weekly consumer contact schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the consumer's person centered recovery plan.
- 11.1.3.1 The team will maintain a central file of all weekly consumer schedules.
 - 11.1.3.2 All weekly consumer schedules shall be made available to DSAMH upon request.
- 11.1.4 The ACT team, under the direction of the team leader, shall develop a daily staff assignment schedule from the central file of all weekly consumer schedules. The daily staff assignment schedule is a written timetable for all the consumer treatment and service contacts and all indirect consumer work (e.g., medical record review, meeting with collaterals, job development, recovery planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.
- 11.1.4.1 The daily staff assignment schedule shall be made available to DSAMH upon request.
- 11.1.5 The daily organizational staff meeting will include a review by the shift manager of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the shift manager will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, and the shift manager will be responsible for assuring that all tasks are completed.

11.1.6 During the daily organizational staff meeting, the ACT team shall also revise person-centered recovery plans as needed, anticipate emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised recovery plans.

11.1.7 The ACT team shall conduct person-centered recovery planning meetings under the supervision of the team leader and the psychiatric prescriber. These recovery planning meetings shall:

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

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

11.1.7.3 Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each consumer and their goals and aspirations and for each consumer to become familiar with TEAM staff;

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

11.1.7.3.2 to problem-solve treatment strategies and rehabilitation options;

11.1.7.3.3 to participate with the consumer and the TEAM in the development and the revision of the person-centered recovery plan;

11.1.7.3.4 to fully understand the recovery plan rationale in order to carry out the plan with each consumer; and

11.1.7.3.5 updated, at a minimum, every 180 days.

12 Staff Supervision

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

12.1.1 Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with consumers in regularly scheduled or crisis meetings to assess their performance, give feedback, and model alternative treatment approaches;

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

12.1.3 Regular meetings with individual staff to review their work with consumers, assess clinical performance, and give feedback;

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

12.1.5 Written documentation of all clinical supervision provided to ACT team staff.

13 Assessment and Person

13.1 Initial Assessment: An initial assessment and recovery plan shall be done the day of the consumer's admission to ACT by the team leader or the psychiatric prescriber, with participation by designated team members.

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

13.2.1 . *Psychiatric History, Mental Status, and Diagnosis:* The psychiatric prescriber is responsible for completing the psychiatric history, mental status, and diagnosis assessment. (Using information derived from the evaluation, a psychiatric prescriber or a clinical or counseling psychologist shall make an accurate diagnosis listed in the American Psychiatric Association's DSM IV.) The psychiatric prescriber presents the assessment findings at the first recovery planning meeting including:

- 13.2.1.1 extent and effects of drug and/or alcohol use;
- 13.2.1.2 medical, dental, and optometric needs;
- 13.2.1.3 adherence to and response to prescribed medical/psychiatric treatment;
- 13.2.1.4 recent key life events;
- 13.2.1.5 vocational and educational functioning;
- 13.2.1.6 family history and social supports;
- 13.2.1.7 current social functioning;
- 13.2.1.8 legal history to include current legal issues;
- 13.2.1.9 financial status;
- 13.2.1.10 conditions of daily living, including
- 13.2.1.11 housing;
- 13.2.1.12 recommendations for treatment to
- 13.2.1.13 include issues to be:
 - 13.2.1.13.1 addressed,
 - 13.2.1.13.2 Referred; and
 - 13.2.1.13.3 deferred.

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

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

- 13.2.4 *Activities of Daily Living (ADL)*: Included in this area is an assessment of the individual's abilities and barriers in meeting day to day activities for independence. This includes but is not limited to:
- 13.2.4.1 Budgeting and money management
 - 13.2.4.2 Shopping for groceries and other personal needs
 - 13.2.4.3 Housekeeping
 - 13.2.4.4 Personal care (bathing, grooming etc...)
 - 13.2.4.5 Laundry
 - 13.2.4.6 Other activities required for independent living.
- 13.2.5 *Family Structure and Relationships*: Included in this area of the assessment is the extent to which family, friends and other supports are currently involved in the consumers care and plans to include the family, friends and other supports in treatment moving forward.
- 13.2.6 *Strengths and Resources*: Members of the consumer's ACT team are responsible for engaging the consumer in his or her own narrative in order to identify individual strengths and resources as well as those within the individual's family, natural support network, service system, and community at large. These may include:
- 13.2.6.1 Personal skills, and talents;
 - 13.2.6.2 personal virtues and traits;
 - 13.2.6.3 interpersonal skills;
 - 13.2.6.4 interpersonal and environmental resources;
 - 13.2.6.5 cultural knowledge;
 - 13.2.6.6 knowledge gained from struggling with adversity;
 - 13.2.6.7 knowledge gained from occupational and parental roles;
 - 13.2.6.8 spirituality and faith;
 - 13.2.6.9 hopes, and dreams; AND
 - 13.2.6.10 goals, and aspirations
- 13.2.7 While the assessment process shall involve the input of most, if not all, team members, the consumer's psychiatric prescriber, primary practitioner, and Team will assume responsibility for preparing the written narrative.
- 13.2.8 The Comprehensive Assessment shall be signed, and dated by:
- 13.2.8.1 the Team completing the evaluation;
 - 13.2.8.2 the psychiatric prescriber AND

13.2.8.3 the clinical supervisor.

13.3 After the assessment formulation is complete, the Team will solicit feedback from the consumer and obtain their signature indicating their degree of participation in the assessment process.

13.4 A copy of the signed assessment shall be made available to the consumer.

13.5 4. The Comprehensive Assessment will be completed within the first thirty days after admission.

14 Physical Examination

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

14.1.1 Results of the current physical examination shall be documented in the consumer 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.

15 Person-Centered Recovery planning

15.1 Person-centered recovery plans will be developed through the following recovery planning process:

15.1.1 The person-centered recovery plan shall be developed in collaboration with the consumer and

15.1.2 his/her preferred natural supporters,

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

15.2 The consumer's participation in the development of the recovery plan shall be documented. The ACT team shall evaluate together with each consumer their:

15.2.1 needs,

15.2.2 abilities,

15.2.3 strengths, and

- 15.2.4 preferences.
- 15.3 The recovery plan shall identify individual :
 - 15.3.1 service needs;
 - 15.3.2 strengths and capacities;
 - 15.3.3 set specific and
 - 15.3.4 measurable
 - 15.3.4.1 long- and short-term goals for
 - 15.3.4.1.1 each service need/issue;
 - 15.3.5 establish the specific approaches and interventions necessary for the consumer to meet his/her goals,
 - 15.3.6 improve his/her capacity to function as independently as possible in the community, and
 - 15.3.7 achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life).
- 15.4 ACT team staff shall meet at regularly scheduled times for recovery planning meetings.
 - 15.4.1 At each recovery planning meeting the following staff should attend:
 - 15.4.1.1 the team leader,
 - 15.4.1.2 the psychiatric prescriber,
 - 15.4.1.3 the primary practitioner,
 - 15.4.1.4 Team
 - 15.4.1.5 the peer specialist and
 - 15.4.1.6 all other ACT team members involved in regular tasks with the consumer.
 - 15.4.2 ACT staff shall make every effort to ensure that the consumer and his/her family and/or natural supports (if desired by the consumer) are in attendance at the recovery planning meeting.
- 15.5 Teams are responsible to provide the necessary support to ensure the consumer is actively involved in the development of:
 - 15.5.1 treatment (recovery) and service goals and
 - 15.5.2 participation in the recovery plan meetings. This may include:
 - 15.5.2.1 offering of peer-based coaching and/or
 - 15.5.2.2 skills training around his/her role in developing their own person centered recovery plan.
 - 15.5.3 With the permission of the consumer, ACT team staff shall also involve pertinent agencies and members of the consumer's social network in the formulation of recovery plans.

- 15.5.4 Each consumer's recovery plan shall identify:
 - 15.5.4.1 service needs/issues,
 - 15.5.4.2 strengths/barriers to success, and
 - 15.5.4.3 goals that are:
 - 15.5.4.3.1 specific and
 - 15.5.4.3.2 measurable.
- 15.5.5 The recovery plan must clearly specify:
 - 15.5.5.1 The approaches and interventions necessary for the consumer to achieve the individual goals (i.e., recovery)
 - 15.5.5.2 and identify who will carry out the approaches and interventions.
- 15.5.6 The following key areas should be addressed in every consumer's person-centered recovery plan unless they are explored and designated as "not of current interest" with signature by the consumer:
 - 15.5.6.1 psychiatric illness
 - 15.5.6.2 symptom reduction;
 - 15.5.6.3 housing;
 - 15.5.6.4 ADL;
 - 15.5.6.5 daily structure and employment;
 - 15.5.6.6 family and social relationships;
 - 15.5.6.7 physical health; and
 - 15.5.6.8 other life areas, goals and aspirations as identified by the consumer (e.g., community activities, empowerment, decision-making).
- 15.5.7 The consumer's own words are reflected in the recovery plan.
- 15.6 The primary practitioner and the team, together with the consumer, will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the consumer's course of treatment (e.g., significant change in consumer's and
 - 15.6.1 At a minimum of every 180 days.
- 15.7 The primary practitioner shall prepare a summary (i.e., recovery plan review) which thoroughly describes in writing the consumer's and the team's:
 - 15.7.1 evaluation of his/ her progress/goal attainment,
 - 15.7.2 The effectiveness of the interventions, and
 - 15.7.3 the satisfaction with services since the last recovery plan.
- 15.8 The plan and review will be signed by:
 - 15.8.1 the consumer,

- 15.8.2 the primary practitioner,
- 15.8.3 Team,
- 15.8.4 the team leader, AND
- 15.8.5 the psychiatric prescriber

15.9 A copy of the signed person-centered plan is made available to the consumer.

16 *Policy and Procedure Requirement:* The ACT team shall maintain written planning policies and procedures incorporating the requirements outlined in this section.

17 Core ACT Services

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

17.2 Services shall minimally include the following:

17.2.1 *Service Coordination* Each consumer will be assigned a primary practitioner who coordinates and monitors the activities of the consumer's team and the greater ACT team.

17.2.1.1 The primary responsibility of the primary practitioner is to work with the consumer to write the person-centered recovery plan,

17.2.1.2 to provide individual supportive counseling,

17.2.1.3 to offer options and choices in the recovery plan,

17.2.1.4 to ensure that immediate changes are made as the consumer's needs change, and

17.2.1.5 to advocate for the consumer's wishes, rights, and preferences.

17.2.1.6 In most cases, the primary practitioner is also the first staff person called on when the consumer is in crisis and is the primary support person and educator to the individual consumer's family.

17.2.1.7 Members of the team share these tasks with the primary practitioner and are responsible to perform the tasks when the primary practitioner is not working.

17.2.1.8 Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

17.2.1.9 Service coordination will incorporate and demonstrate basic recovery values.

17.2.1.10 The consumer will have ownership of his or her own treatment.

17.2.1.10.1 The consumer will be expected to take the primary role in person-centered recovery plan development,

17.2.1.10.2 play an active role in treatment decision making, and

17.2.1.10.3 be allowed to take risks,

17.2.1.10.4 make mistakes and

17.2.1.10.5 learn from those mistakes.

17.3 Crisis Assessment and Intervention

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

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

17.3.3 The Crisis Intervention and CAPES programs as appropriate will provide adjunctive crisis intervention.

17.3.4 Whenever possible, a representative from the ACT team will be present to support the ACT consumer when external crisis responders are involved with the consumer.

17.3.5 Each ACT consumer will have an individualized, strengths based crisis plan.

17.3.6 the consumer will take the lead role in developing the crisis plan.

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

17.4.1 Psychoeducation regarding:

17.4.1.1 mental illness and

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

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

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

17.4.4 Psychotherapy, including

17.4.4.1 individual supportive therapy

17.4.4.2 Group Therapy

17.4.4.3 and family therapy when appropriate.

17.4.5 Generous psychological support to consumers, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.

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

17.5.1 Defining and identifying the consumer's recovery goals within the consumer's frame of reference.

17.5.2 Developing strategies for implementing and maintaining the identified recovery goals.

17.5.3 Psychoeducation and providing the consumer with practical information about mental illness and the consumer's diagnoses and experiences with mental illness.

17.5.4 Skills training and practice:

17.5.4.1 in how to develop social supports.

17.5.4.2 for the consumer in understanding and implementing coping skills to decrease stress

17.5.4.3 for the effective use of medication.

17.5.4.4 defining relapse,

17.5.4.5 identifying triggers for relapse and

17.5.4.6 strategies for reducing relapses in frequency and severity.

17.5.4.7 for identifying individualized stressors and coping positively with those stressors.

17.5.4.8 for identifying and coping with individualized symptoms.

17.5.4.9 practice for getting consumer's needs met within the mental health system, including empowerment and self-advocacy.

17.5.4.10 Direct assistance with learning and practicing new skills as they are developed.

18 Medication Prescription, Administration, Monitoring and Documentation

18.1 The ACT team psychiatric prescriber shall:

18.1.1 Establish an individual clinical relationship with each consumer

18.1.2 Assess each consumer's mental illness symptoms and provide verbal and written information about mental illness.

18.1.3 review clinical information with the consumer, and as appropriate, with the consumer's family members or significant others.

- 18.1.4 Make an accurate diagnosis based on direct observation, available collateral information from the family and significant others and the comprehensive assessment.
- 18.1.5 Provide a diagnostic work-up that will dictate an evidence-based medication pathway that the psychiatric prescriber will follow.
- 18.1.6 Provide to the consumer, and as appropriate, the consumer's family and/or significant others, practical education about medication, including:
 - 18.1.6.1 benefits and
 - 18.1.6.2 risks of various medication strategies.
 - 18.1.6.3 The prescriber will obtain informed consent from the consumer for all medications prescribed.
 - 18.1.6.4 In collaboration with the consumer, assess, discuss and document the consumer's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects.
 - 18.1.6.5 Provide psychotherapy, including:
 - 18.1.6.5.1 individual supportive therapy,
 - 18.1.6.5.2 psychoeducation,
 - 18.1.6.5.3 symptom management, and
 - 18.1.6.5.4 cognitive behavioral approaches.
- 18.2 All ACT team members shall assess and document the consumer's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.
 - 18.2.1 Observations will be reviewed with the consumer.
- 18.3 The ACT team program shall establish medication policies and procedures which identify processes to:
 - 18.3.1 Record physician orders.
 - 18.3.2 Order medication.
 - 18.3.3 Arrange for all consumer medications to be organized by the team and integrated into consumers' weekly schedules and daily staff assignment schedules.
 - 18.3.4 Provide security for medications (e.g., long-term injectable, daily, and longer term and
 - 18.3.5 set aside a private designated area for set up of medications by the team's nursing staff.
 - 18.3.6 Administer medications per state law to team consumers.

19 Co-Occurring Disorders Services

19.1 ACT consumers will receive a comprehensive chemical dependency assessment during the first month of treatment. The assessment will include:

- 19.1.1 Substance use history.
- 19.1.2 Parental and familial substance use summary.
- 19.1.3 Effects/imACT of substance use.
- 19.1.4 Functional assessment: role played by substances in the consumer's life.
- 19.1.5 Consumer strengths.
- 19.1.6 Social support network (including both users and people who support recovery)
- 19.1.7 Consumer's self-identified goals and aspirations
- 19.1.8 ACT consumers will receive integrated, treatment that is:
- 19.1.9 nonconfrontational,
- 19.1.10 considers interactions of mental illness and substance abuse, and
- 19.1.11 has consumer-determined goals.

19.2 Treatment will follow a harm reduction model. This shall include but is not limited to:

- 19.2.1 individual and
- 19.2.2 group interventions in:
- 19.2.3 Developing motivation for decreasing use.
- 19.2.4 Developing skills to minimize use,
- 19.2.5 recognition of negative consequences of use, and
- 19.2.6 adoption of an abstinence goal for treatment.
- 19.2.7 Engagement (e.g., empathy, reflective listening, avoid argumentation)
- 19.2.8 Assessment (e.g., stage of readiness to change, consumer-determined problem identification)

19.3 Motivational enhancement (e.g., developing discrepancies, psychoeducation)

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

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

20 Education Services:

20.1 *Supported Education:* Supported education related services are for ACT consumers whose high school, college or vocational education could not start or was interrupted. Services provide support:

- 20.1.1 to enrolling and participating in educational activities.
- 20.1.2 Strengths-based assessment of educational interests, abilities and history.

- 20.1.3 Pre-admission counseling to determine which school and/or type of educational opportunities may be available.
 - 20.1.4 If, indicated referral to GED classes and testing.
 - 20.1.5 Assistance with completion of applications and financial aid forms.
 - 20.1.6 Help with registration.
 - 20.1.7 Orientation to campus buildings and school services.
 - 20.1.8 Assessment of learning style and study skills.
 - 20.1.9 Early identification and intervention with academic difficulties.
 - 20.1.10 Linking with academic supports such as tutoring and learning resources.
 - 20.1.11 Assistance with time management and schoolwork deadlines.
 - 20.1.12 Supportive counseling.
 - 20.1.13 Information regarding disclosing mental illness.
 - 20.1.14 Advocating with faculty for reasonable accommodations.
- 21 Vocational Services:
- 21.1 *Vocational Services* include work-related services to help consumers value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers. Services include but are not limited to:
 - 21.1.1 Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
 - 21.1.2 Assessment of the effect of the consumer's mental illness on employment with identification of specific behaviors that help and hinder the consumer's work performance and
 - 21.1.2.1 development of interventions to reduce or eliminate any hindering behaviors and find effective job accommodations.
 - 21.1.3 Job development activities.
 - 21.1.4 Development of an ongoing employment rehabilitation plan to help each consumer establish the skills necessary to find and maintain a job
 - 21.1.5 Individual supportive therapy to assist consumers to identify and cope with the symptoms of mental illness that may interfere with their work performance.
 - 21.1.6 Development of a consumer-driven, on-the-job or work-related crisis intervention plan.
 - 21.1.6.1 The plan will identify early triggers for intervention.
 - 21.1.7 Provision of on-the-job or work-related crisis intervention services.

21.1.8 Work-related supportive services, such as assistance with resume development, job application preparation, interview support, grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation.

22 Activities of Daily Living Services

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

22.1.1 individualized assessment,

22.1.2 problem solving,

22.1.3 skills training/practice,

22.1.4 sufficient side-by-side assistance and support,

22.1.5 modeling,

22.1.6 ongoing supervision (e.g. prompts, assignments, monitoring, encouragement),

22.1.7 environmental adaptations to assist consumers to gain or use the skills required to:

22.1.7.1 Find housing which is safe,

22.1.7.2 good quality, and

22.1.7.3 affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating;

22.1.7.4 and procuring necessities (such as telephones, furnishings, linens)

22.1.7.5 Perform household activities, including:

22.1.7.5.1 house cleaning,

22.1.7.5.2 cooking,

22.1.7.5.3 grocery shopping, and

22.1.7.5.4 laundry

22.1.7.6 Carry out personal hygiene and grooming tasks, as needed

22.1.7.7 Develop or improve money-management skills

22.1.7.8 Use available transportation

22.1.7.9 Have and effectively use a personal physician and dentist

23 Social and Community Integration Skills Training

23.1 Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skill training and include:

- 23.1.1 supportive individual therapy (e.g., problem solving, role-playing, modeling, and support);
- 23.1.2 social-skill teaching and assertiveness training;
- 23.1.3 planning, structuring, and prompting of social and leisure-time activities;
- 23.1.4 side-by-side support and coaching;
- 23.1.5 organizing individual and group social and recreational activities to structure consumers' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:
 - 23.1.5.1 Improve communication skills,
 - 23.1.5.2 develop assertiveness, and increase self-esteem, as necessary
 - 23.1.5.3 increase social experiences, and
 - 23.1.5.4 where appropriate, develop meaningful personal relationships
 - 23.1.5.5 Plan appropriate and productive use of leisure time
 - 23.1.5.6 Relate to landlords, neighbors, and others effectively
 - 23.1.5.7 Familiarize themselves with available social and recreational opportunities
 - 23.1.5.8 and increase their use of such opportunities

24 Peer Support Services

- 24.1 These include services to validate consumers' experiences and to guide and encourage consumers to take responsibility for and actively participate in their own recovery, as well as services to help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce consumers' self-imposed stigma. Peer Support and Wellness Recovery Services include:
 - 24.1.1 Peer counseling and support services, including those which:
 - 24.1.1.1 Promote self-determination and
 - 24.1.1.2 Encourage and reinforce choice and decision making.
 - 24.1.2 Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.
- 24.2 The Peer Specialist will serve as a consultant to the ACT team to support a culture of recovery in which each consumer's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, support, and community activities.

25 Support Services

25.1 Support services, to include skills training for accessing services, and providing direct assistance when necessary, to ensure that consumers obtain the basic necessities of daily life, including but not necessarily limited to:

- 25.1.1 Medical and dental services
- 25.1.2 Safe, clean, affordable housing
- 25.1.3 Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance)
- 25.1.4 Social service
- 25.1.5 Transportation
- 25.1.6 Legal advocacy and representation

26 Family and Natural Supports' Psychoeducation and Support

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

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

27 ORGANIZATIONAL STANDARDS

- 27.1 Community Support Services programs shall establish an advisory committee, which meets at least quarterly and includes peers, program consumers and family members of consumers within its membership. The function of the advisory committee shall be to ensure consumer and family participation in the process of setting and evaluating the values, mission, goals, objectives and service strategies of the program and to assist the program in representing its interest to the community in which it operates.
- 27.2 The advisory committee shall have written rules governing the conduct of its meetings which specify at least the following:
- 27.2.1 Its authority and duties;
 - 27.2.2 Officers and committees;
 - 27.2.3 Criteria, types, methods of membership;
 - 27.2.4 Frequency of meetings;
 - 27.2.5 Attendance requirements.
 - 27.2.6 Minutes of advisory committee meetings shall be kept and shall include the following:
 - 27.2.6.1 Date of meeting;
 - 27.2.6.2 Attendance;
 - 27.2.6.3 Topics discussed;

- 27.2.6.4 Decisions reached;
- 27.2.6.5 Actions planned or taken;
- 27.2.6.6 Reports from sub-committees.

27.3 The facility(ies) within which the CCCP operates shall meet the following criteria:

- 27.3.1 They shall maintain a Certificate of Occupancy;
- 27.3.2 They shall meet all applicable fire and life safety codes;
- 27.3.3 They shall be maintained in a clean and safe condition;
- 27.3.4 They shall provide rest rooms maintained in a clean and safe condition available to consumers, visitors and staff;
- 27.3.5 They shall be accessible to the consumer served;
- 27.3.6 They shall provide a smoke free environment.

28 . Consumer Rights and Grievance Procedures

28.1 ACT teams shall be knowledgeable about and familiar with consumer rights including the rights to:

- 28.1.1 Confidentiality
- 28.1.2 Informed consent to medication and treatment
- 28.1.3 Treatment with respect and dignity
- 28.1.4 Prompt, adequate, and appropriate treatment
- 28.1.5 Treatment which is under the least restrictive conditions
- 28.1.6 Nondiscrimination
- 28.1.7 Control of own money
- 28.1.8 Voice or file grievances or complaints

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

- 28.2.1 Grievance or complaint procedures under:
 - 28.2.1.1 Medicaid
 - 28.2.1.2 Americans with Disabilities Act
 - 28.2.1.3 Protection and Advocacy for Mentally Ill Individuals

28.3 ACT teams shall be prepared and provide consumers with appropriate information referral to the Protection and Advocacy agency and other advocacy groups.

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

- 28.5 ACT teams will also ensure that consumers receive services in their preferred language and will make arrangements for interpreter services.

29 ADMINISTRATIVE STANDARDS

29.1 Consumer Records

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

- 29.2 There shall be a designated consumer record manager who shall be responsible for the maintenance and security of consumer records.

- 29.3 The record keeping format and system for purging shall provide for consistency, facilitate information retrieval and shall be approved by the Division.

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

- 29.5 The active consumer record shall contain the following:

- 29.5.1 A minimum of the program's last 12 months treatment records for the consumer;
- 29.5.2 An up-to-date face sheet;
- 29.5.3 Consent to treatment signed by the consumer;
- 29.5.4 Consent to any occasion of release of information
- 29.5.5 Documentation that the consumer has been informed of his/her rights;
- 29.5.6 Documentation that the consumer has been provided with information regarding the process by which grievances can be addressed;
- 29.5.7 Copies of any grievances filed by the consumer;
- 29.5.8 Reports from all examinations, tests and clinical consults;
- 29.5.9 Hospital discharge summaries;
- 29.5.10 Comprehensive medical psychosocial evaluation;
- 29.5.11 Comprehensive recovery plan/recovery plan updates;
- 29.5.12 Crisis intervention plan and updates;
- 29.5.13 Summary of monthly consumer activity;

- 29.5.14 Progress notes;
- 29.5.15 Documentation of clinical supervision;
- 29.5.16 Medication records;
- 29.5.17 Discharge documentation.

30 Procedure Manual

30.1 The Community Support Services program shall maintain a written procedure manual for its staff. A mechanism shall be in place to ensure that the procedure manual is updated continuously and that the staff of the program is notified promptly of changes. The manual shall include:

- 30.1.1 A statement of the program's values, mission and objectives;
- 30.1.2 Referral policies and procedures that facilitate consumer referral;
- 30.1.3 Detailed instructions for assessment, service planning and documentation procedures;
- 30.1.4 Policies and procedures for medication management In compliance with all applicable rules, regulations and requirements of the Delaware Board of Medical Practice, the Delaware Board of Nursing and the Delaware Board of Pharmacy (if applicable) to include policies and procedures for:
 - 30.1.4.1 Prescribing medication;
 - 30.1.4.2 Storage of medication;
 - 30.1.4.3 Handling of medication;
 - 30.1.4.4 Distribution of medication;
 - 30.1.4.5 Dispensing of medication;
 - 30.1.4.6 Disposing of medication;
 - 30.1.4.7 Recording of medication used by consumers.
- 30.1.5 Policies and procedures for handling on-call responsibilities and consumer emergencies;
- 30.1.6 Detailed instructions for application to and communication with entitlement authorities;
- 30.1.7 Policies and procedures for sharing of information about consumers with family members or others;
- 30.1.8 Policies and procedures regarding committing and handling financial resources of the program;
- 30.1.9 Policies and procedures regarding the management of consumer's funds for whom the program has been designated payee;

30.1.10 Policies and procedures for the receipt, consideration and resolution of consumer complaints and/or grievances regarding treatment decisions and practices or other program activities.

30.1.11 Other policies and procedures as maybe promulgated or required by the Division and/or DHSS/DMAP.

31 Personnel Management

31.1 The Community Support Services Programs or parent organization 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:

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

31.1.1.1 The Americans with Disabilities Act and the Vocational Rehabilitation Act of 1973, Sections 503 and 504 prohibiting discrimination against the handicapped;

31.1.1.2 Title VII of the Civil Rights Act of 1964 prohibiting discrimination on the basis of race, color, creed, sex or national origin;

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

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

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

31.1.2 Policies and procedures for interviews and selection of candidates including verification of credentials and references;

31.1.3 Policies and procedures for employee performance appraisal;

31.1.4 A code of ethics;

31.1.5 Conditions and procedures for termination of employment;

31.1.6 Conditions and procedures for grievances and appeals;

31.1.7 An annual staff development plan which shall include:

31.1.7.1 Provisions for orientation of paid staff, student interns and volunteers.

Orientation shall include:

31.1.7.1.1 Review of these standards;

31.1.7.1.2 Review of the program's procedures and personnel manuals;

31.1.7.1.3 Review of DHSS Policy Memorandum #46;

31.1.7.1.4 Review of section 5161 of Title 16;

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

31.1.7.1.6 Review of 42 C.F.R. Part 2.

31.1.7.2 Provisions for continuing education of staff;

- 31.1.7.3 Provisions for regularly scheduled, face-to-face clinical supervision which teach and enhance the clinical skills of staff including:
 - 31.1.7.3.1 Individual face-to-face sessions between the clinical supervisor and staff to review cases, assess performance and give feedback;
 - 31.1.7.3.2 Individual, side-by-side sessions during which the clinical supervisor attends clinical sessions conducted by staff to assess performance, teach clinical skills and give feedback.
 - 31.1.7.4 Maintenance and access to personnel files which shall contain employees' applications, credentials, job descriptions, and performance appraisals, job titles, training, orientation, salary, staff statement of confidentiality.
 - 31.1.7.5 Work hours including hours of program operation, shifts and overtime compensation.
 - 31.1.7.6 Agency policies regarding compensation including:
 - 31.1.7.6.1 salary ranges, salary increases, and payroll procedures;
 - 31.1.7.7 Use of personal automobile for program activities;
 - 31.1.7.8 Reimbursement for work related expenses;
 - 31.1.7.9 10.3.1.10.4 Description of employee benefits.
- 31.2 ACT teams should implement strategies to recruit, retain, and promote a diverse staff that are representative of the demographic characteristics of the service area.
 - 31.3 ACT teams should ensure that staff at all levels and across all disciplines receives ongoing education and training in culturally and linguistically appropriate service delivery.
 - 31.4 ACT teams must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each consumer with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.
 - 31.5 ACT teams must provide to consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
 - 31.6 ACT teams must assure the competence of language assistance provided to limited English-proficient consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except by request of the consumer).
 - 31.7 ACT teams should ensure that staff at all levels and across disciplines receives ongoing education and training in appropriate services to members of the lesbian,

gay, bisexual, transgendered, queer/queer questioning/identified, and two spirit people communities (LGBTQ/2SP).

32 Performance improvement Program

32.1 The Community Support Services 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 following performance improvement mechanisms which shall be carried out in accordance with the performance improvement plan:

32.1.1 A statement of the program's objectives. The objectives shall relate directly to the program's consumers or target population.

32.1.2 Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.

32.1.3 Methods for documenting achievements related to the program's stated objectives.

32.1.4 Methods for assessing the effective use of staff and resources toward the attainment of the objectives.

32.1.5 In addition to the performance improvement and program evaluation plan, the ACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

32.1.6 The ACT team shall maintain performance improvement and program evaluation policies and procedures that include:

32.1.6.1 a concurrent utilization review process;

32.1.6.2 a retrospective performance improvement review process;

32.1.6.3 a process for clinical care evaluation studies; and

32.1.6.4 a process for self-survey for compliance with the certification standards and ACT Fidelity as prescribed by The Division.

32.2 The CCCP should ensure that data on the individual consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and be periodically updated.

32.3 The CCCP should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing culturally aware activities.

33 WAIVER OF PROVISIONS

33.1 The Division Director of DSAMH or her/his designee, may issue a waiver of any of the discretionary requirements of these certification standards upon the good-cause-shown request of a program seeking certification/re-certification. Such request for a waiver must demonstrate that the waiver will not in any substantial or material manner have a deleterious effect on the essential quality of services to the consumer and offer an alternative procedure for the standard that waiver is requested for.

33.2 Waivers issued by the Director or her/his designee shall be in writing and shall specify the maximum duration of the waiver's effect.

33.3 Any waiver issued by the Director or her/his designee may be rescinded at any time at the discretion of the Director and will be rescinded if deleterious effect on the essential quality of service to the consumer is evidenced.

33.3.1 Extensions and/or renewals of any waiver shall be made at the Director's discretion.

SECTION 4 – ASAM INFORMATION

ASAM CLINICAL PLACEMENT SUMMARY

(Section 1)

Demographics and Status Request

Today's Date: _____

Assessor/Therapist (print): _____ Phone/ext.: _____ FAX # _____

Signature of Assessor/Therapist: _____

Consumer Last name (print): _____ First: _____ MI.: _____

SS#: _____ DOB: _____ Age: _____

Gender Expression: ___ (M) ___ (F) Marital Status: _____ Ethnicity: _____

TASC Client: Yes ___ No ___ Unknown ___ Probation Officer: _____

MCI # _____ (if known) Source and Amount of Income: _____

Medicaid #: _____ Medicare # _____ Other Insurance (specify): _____

Current Residence (type): _____

Indicate whether the applicant lives in a private residence (supervised or unsupervised), Adult Foster Care, Boarding House, Group Setting (supervised or supervised), psychiatric inpatient facility (provide name), Nursing Home (specify), other Institutional Setting (specify), homeless or other (explain)

Current Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person to Contact in Case of an Emergency: _____

Address: _____

Telephone Number: _____ Relationship: _____

Primary Language: () English () Spanish () American Sign Language () Other: _____

Does the enrollee have a representative payee? ___ (no) _____ (yes/specify)

Date of **most recent** Assessment or Assessment Update completion (if applicable): _____ Appeal: Yes ___ No ___

Status Request: ADMISSION ___ LOC Requested: _____

CONTINUED STAY ___: Specify number of days requested at current LOC: _____

DISCHARGE (No more treatment needed.) _____

REFERRAL (Treatment to be provided by a different program) _____

TRANSFER (Treatment to be provided at the same program at a different intensity) _____

ASAM CLINICAL PLACEMENT SUMMARY

(Section 2)

Current Diagnoses and Symptoms

Axis I: Clinical Disorder

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis II: Personality Disorders/Mental Retardation

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Please describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis III: General Medical Conditions (ICD-9-CM name) Use additional space if needed.

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Please describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis IV: Psychosocial and Environmental Problems (Check and Describe):

Problems with primary support group (specify) _____

Problems related to the social environment (specify) _____

Educational problems (specify and indicate the highest grade completed) _____

Occupational problems (specify) _____

Housing problems (specify) _____

Economic problems (specify) _____

Problems with access to health care (specify) _____

Problems related to interaction with the legal system/crime (specify) _____

History of trauma (specify) _____

Other psychosocial and environmental problems (specify) _____

Axis V: Global Assessment of Functioning Scale:

Current: _____ Highest level in the past year: _____

Diagnostician: Psychiatrist or other authorized person who performed the evaluation and formulated the diagnosis:

(Print Name) _____

(Signature) _____

Phone #: _____ Date of Diagnosis: _____

ASAM CLINICAL PLACEMENT SUMMARY

(Section 3)

A. What is the most important thing you want or made you decide to call or come in for help right now? What is most important to you that you would like help with right now?

B. Immediate Need Profile

Consider each dimension and with just sufficient data to assess immediate needs, checks "yes" or "no" for the following questions:

1. Acute Intoxication and/or Withdrawal Potential

(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospitalization for seizure control; psychosis with DT's; medication management with close nurse monitoring and medical management? ___No___ Yes; (b) Currently having severe, life-threatening and/or similar withdrawal symptoms? ___No___ Yes

2. Biomedical Conditions/Complications

Any current severe physical health problems? e.g., bleeding from mouth or rectum in past 24 hours; recent, unstable hypertension; recent, severe pain in chest, abdomen, head; significant problems in balance, gait, sensory or motor abilities not related to intoxication. ___No___ Yes

3. Emotional/Behavioral/Cognitive Conditions/Complications

(a) Imminent danger of harming self or someone else? e.g., suicidal ideation with intent, plan and means to succeed; homicidal or violent ideation, impulses and uncertainty about ability to control impulses, with means to act on. ___No___ Yes; (b) Unable to function in activities of daily living, care for self with imminent, dangerous consequences? e.g., unable to bath, feed, groom and care for self due to psychosis, organicity or uncontrolled intoxication with threat of imminent safety to self, others as regards death or severe injury ___No___ Yes

4. Readiness to Change

(a) Does client appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK; psychotic, but blames a conspiracy ___No___ Yes; (b) Client has been coerced, mandated or required to have assessment and/or treatment by mental health court or criminal justice system, health or social services, work/school, or family/significant other? ___No___ Yes

5. Relapse/Continued Use/Continued Problem Potential

(a) Is client currently under the influence and/or acutely psychotic, manic, suicidal? ___No___ Yes; (b) Is client likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate containment? (c) Is client's most troubling, presenting problem(s) that brings the client for assessment, dangerous to self or others? (See examples above in dimensions 1, 2 and 3) ___No___ Yes

6. Recovery Environment

Are there any dangerous family, sig. others, living/work/school situations threatening client's safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures ___No___ Yes

IMPORTANT

- Yes to questions 1a and 1b; or 1b alone; 2 and/or 3 requires that the caller/client immediately receive medical or psychiatric care for evaluation of need for acute, inpatient care. **TAKE IMMEDIATE ACTION. STOP THE ASSESSMENT HERE.**
- Yes to questions 4a and/or 4b alone, requires caller/client to be seen for assessment within 48 hrs, and preferably earlier, for motivational strategies, unless patient imminently likely to walk out and needs a more structured intervention.
- Yes to question 5a alone, assess further for need for immediate intervention e.g., taking keys of car away; having a relative/friend pick client up if severely intoxicated and unsafe; evaluate need for immediate psychiatric intervention.
- Yes to questions 5b, 5c and/or 6, without any Yes in questions 1, 2 and/or 3, requires that the caller/client be referred to a safe or supervised environment e.g., shelter, alternative safe living environment, or residential or sub-acute care setting depending on level of severity and impulsivity.

ASAM CLINICAL PLACEMENT SUMMARY

C. ASAM Dimensions: Provide a brief narrative for each dimension that explains your Rating of Severity/Function. Focus on brief relevant history information and relevant here and now information. CHECK ALL ITEMS THAT APPLY

Dimension 1: Acute Intoxication and/or Withdrawal Potential - Substance Use: Include Amount, Duration and Last Use for each substance (except "no known risk," explain any item checked)

- No known risk
- Adequate ability to tolerate/cope with intoxication or withdrawal symptoms
- Some difficulty tolerating/ coping with intoxication or withdrawal discomfort
- Past history of complicated withdrawal needing medical intervention
- Current potential for complicated withdrawal needing medical intervention
- Use is current and complicated withdrawal needing medical intervention is imminent

Dimension 2: Biomedical conditions/complications (except "no known," explain any item checked)

- No known biomedical conditions/complications
- Current physical illnesses exist, and are: stable unstable acute (circle as appropriate)
- There is a history of chronic conditions

Dimension 3: Emotional/Behavioral/Cognitive Conditions or Complications:

SUICIDALITY (except "no history," explain any item checked)

- No history or current suicidal ideation
- Has frequent passive thoughts of being better off dead
- Exhibits suicidal ideation without a plan
- Exhibits suicidal ideation with a plan
- Has recently attempted suicide or made credible threats with a plan and means
- Has a history of suicidal gestures or threats

SELF-CONTROL/IMPULSIVITY (except "no history," explain any item checked)

- Has no history of self-control/impulsivity issues
- Is involved with the judicial or legal system
- Has been arrested for alcohol- or drug-related crimes, or for use/possession/distribution of drugs, for minor theft, destruction of property, vagrancy/loitering, disturbing the peace, or public intoxication within the past 6 months
- Currently experiencing problems related to gambling
- Has a history of arrests for illegal or unsafe activities

ASAM CLINICAL PLACEMENT SUMMARY

DANGEROUSNESS (except "no known history," explain any item checked)

- Has no known history of dangerousness
- Lacks impulse control/control of violent behavior
- Has a history of violent or dangerous social behavior
- Exhibits inappropriate or dangerous social behavior dangerous to others, e.g. physical or sexual assault, fire setting
- Engages in behavior dangerous to himself/herself
- Engages in behavior dangerous to property
- Engages in behavior that leads to victimization

SELF-CARE (except "no self-care deficits," explain any item checked)

- No self-care deficits noted
- Does not seek appropriate treatment/supportive services without assistance or requires significant oversight to do so; needs services to prevent relapse
- Requires assistance in basic life and survival skills (i.e. locating food, finding shelter)
- Requires assistance in basic hygiene, grooming and care of personal environment
- Engages in impulsive, illegal or reckless behavior
- Experiences frequent crisis contacts (___ (number) within ___ (number) months)
- Experiences frequent detoxification admissions (___ (number) within ___ (number) months)

PSYCHIATRIC/EMOTIONAL HEALTH (except "does not exhibit signs/symptoms," explain any item checked)

- Does not exhibit signs/symptoms of psychiatric or emotional illness
- Psychiatric symptoms are well managed with medication/treatment
- Symptoms persist in spite of medication adherence
- Psychiatric symptoms and signs are present and debilitating
- Experiences delusions and/or hallucinations which interfere with client's ability to function
- Acute or severe psychiatric symptoms are present which seriously impair client's ability to function
- Currently taking medications for these symptoms (list below)
- Medication adherence is inconsistent
- Experiences mood abnormality (depression, mania)
- Is frequently very anxious or tense
- Is unable to appropriately express emotions
- Experiences hopelessness, apathy, lack of interest in life
- Experiences physical symptoms related to their psychiatric illness or addiction (e.g. sleeplessness, stomach aches)
- Lacks any sense of emotional well-being

ASAM CLINICAL PLACEMENT SUMMARY

Current medications and dosages. You may attach a copy of your Medication Administration Record (MAR) or order sheet if it is legible.

Medication	Dosage	Effectiveness
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

When available attach the most recent laboratory tests results, including tests for therapeutic drug levels, alcohol/drug screens, Complete Blood Count (CBC), Complete Metabolic Profile (CMP), Thyroid Stimulating Hormone (TSH) and any other diagnostic studies.

Other Comments about medications and dosage: _____

Dimension 4: Readiness to Change:

UNDERSTANDING OF ILLNESS AND RECOVERY (explain any item checked)

- Exhibits understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Exhibits some understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Little or no understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Limited understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects
- Does not have an understanding of his/her illness(es) and recovery

DESIRE TO CHANGE (explain any item checked)

- States desire to change
- Indicates some desire to change
- Limited desire or commitment to change
- Doesn't understand the need to change
- Relates to treatment with some difficulty and establishes few, if any trusting relationships
- Does not use available resources independently or only in cases of extreme need
- Does not have a commitment to recovery

ASAM CLINICAL PLACEMENT SUMMARY

Dimension 5: Relapse, Continued Use, Continued Problem Potential:

CURRENT AND PREVIOUS TREATMENT HISTORY AND RESPONSE (explain any item checked)

- Takes medication with good response/complete remission of symptoms
- Takes medications (with or without assistance) as prescribed with continued symptoms/partial remission of symptoms
- Not using but no behavioral changes to support recovery
- Not taking prescribed medications with a history of violence
- Previous or current treatment has not achieved remission of symptoms
- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved
- Attempts to maintain treatment gains have had limited success
- Has had extensive and intensive treatment
- Has had some treatment
- This is the first treatment
- Court ordered to treatment ____ (civil) ____ (criminal)

Treatment Service history. Include all inpatient and outpatient treatment. We are particularly interested in the past 24 months or since last placement summary. If more space is needed, attach additional page(s).

DATES		PROVIDER	Effectiveness (treatment goals met, premature discharge before goals met; problems encountered)
FROM	TO		

RELAPSE PREVENTION, ILLNESS MANAGEMENT AND COPING (explain any item checked)

- Has awareness of relapse triggers and ways to cope with MH breakthrough symptoms and/or substance use cravings
- Has some awareness of relapse triggers and ways to cope with MH breakthrough symptoms and/or substance use cravings
- Is unaware of relapse triggers and ways to cope with mental health breakthrough symptoms and/or substance use cravings
- Lacks skills to control impulses to use or harm self or others
- Doesn't follow medication regimen
- Requires assistance and/or support to actively manage relapse prevention
- Tolerates organized daily activities or environmental changes
- Exhibits some tolerance for organized daily activities or environmental changes
- Has little tolerance for organized daily activities or environmental changes
- Is unable to tolerate organized daily activities or environmental changes (e.g. activities or changes cause agitation, exacerbation of symptoms or withdrawal)
- Is unable to cope with stressful circumstances associated with work, school, family or social interaction
- Lack of resilience in response to stress

ASAM CLINICAL PLACEMENT SUMMARY

Dimension 6: Recovery Environment:

RECOVERY ENVIRONMENT: (except "safe affordable housing of own choosing," explain any item checked)

- Resides in safe affordable housing of own choosing
 - Resides in safe affordable housing but is not of own choosing
 - Resides in licensed Adult Foster Care
 - Resides in unlicensed Adult Foster Care
 - Resides in a Group Home
 - Resides in Supervised Housing/Apartment
 - Living arrangement puts client at risk of harm
 - Living environment increases client's stress
 - Unable to or only marginally able to support themselves in independent housing
 - At risk of eviction due to behavioral health problems
 - At risk of homelessness for other reasons (e.g. family refuses to allow a return to the home, community complaints...)
 - Homeless
 - There is serious disruption of family or social milieu due to illness, death, severe conflict, etc.
 - Estranged from their family
 - Significant difficulties in interacting with family members
 - Lacks ability to provide food for self or dependent children
 - No transportation
 - No child care presenting a barrier to participate in treatment
 - Language barriers interfere with full participation in treatment
 - Resides in environment where easily victimized
-
-
-

INTERPERSONAL/SOCIAL FUNCTIONING (explain any item checked)

- Has several close relationships or group affiliations
 - Has one or two close relationships or group affiliations
 - Lacks connections to supportive social systems in the community
 - Unable to form close friendships or group affiliations
 - Unable to interact appropriately with family and/or the community
 - Unable to engage in meaningful activities
 - Is socially isolated
 - Is in abusive relationship(s)
-
-
-

ASAM CLINICAL PLACEMENT SUMMARY

D. Rating of Severity/Function: Using assessment protocols that address all six dimensions, assign a severity rating of 0 to 4 for each dimension that best reflects the client's functioning and severity. Place a check mark or rating in the appropriate box for each dimension. **If applicable, for dimensions 4 and 5, rate mental health, substance use and physical health separately.**

Risk Ratings	Intensity of Service Need	Dimensions					
		1.	2.	3.	4.	5.	6.
(0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed.						
(1) Mild - Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings						
(2) Moderate - Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Moderate intensity of services, skills training, or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.						
(3) Significant – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in, or near imminent danger.						
(4) Severe - Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater than daily.						

(Section 4)

E. Placement Decisions: Indicate for each dimension, the least intensive level consistent with sound clinical judgment, based on the client's functioning/severity and service needs

ASAM PPC-2R Level of Detoxification Service	Level	Dimen. 1 Intoxic/ Withdr.					
Ambul. Detox without Extended On-Site Monitor.	I-D						
Ambul. Detox with Extended On-Site Monitoring	II-D						
Clinically-Managed Residential Detoxification	III.2-D						
Medically-Monitored CD Inpatient Detoxification	III.7-D						
Medically-Managed Intensive Inpatient Detox.	IV-D						
ASAM PPC-2R Level of Care for Other Treatment and Recovery Services *	Level *		Dimen. 2 Biomed.	Dimen. 3 Emot/ Behav/ Cognitive	Dimen. 4 Readiness to Change	Dimen. 5 Relapse, Continued Use/Problem	Dimen. 6 Recovery Environ.
Early Intervention / Prevention	0.5						
Outpatient Services / Individual	I						
Outpatient with Care Manager	I.2						
Intensive Outpatient Treatment (IOP)	II.1						
CCCP (ICM/TCM)	II.2						
CCCP (ACT)	II.3						
Partial Hospitalization (Partial)	II.5						
Apartments /Clinically-Managed Low-Int. Res. Svcs., Shelter	III.1						
Clinically-Managed Med-Intens. Residential Svcs.	III.3						
Clinically-Managed High-Intens. Residential Svcs	III.5						
Medically-Monitored Intens. Inpatient Treatment	III.7						
Medically-Managed Intensive Inpatient Services	IV						
Opioid Maintenance Therapy	OMT						

ASAM CLINICAL PLACEMENT SUMMARY

PLACEMENT SUMMARY

<p>Level of Care/Service Indicated - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter</p>	
<p>Level of Care/Service Received - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level of Service</p>	
<p>Reason for Difference - Circle only one number -- 1. No difference; 2. Service not available; 3. Provider judgment; 4. Client preference; 5. Client is on waiting list for appropriate level; 6. Service available, but no payment source; 7. Geographic accessibility; 8. Family responsibility; 9. Language; 10. Court Ordered; 11. Not listed (Specify):</p>	
<p>Anticipated Outcome If Service Cannot Be Provided – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in higher level of care; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Probation Violation; 7. Not listed (Specify):</p>	

Client Strengths that will help him/her be successful at this level of care:

Possible Barriers to treatment:

ADDITIONAL COMMENTS: (Please use the space below for additional comments about placement for this client.)
