

Chapter

6

Additional Requirements for Selected Services

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Chapter

6

Additional Requirements for Selected Services

Introduction

This section of the manual serves to present policy, procedure, and guidelines which relate to the additional requirements for selected services at Richmond Behavioral Health Authority. It describes the flow of the service delivery process, from a consumer's entry into and progress through the Agency's service delivery system to discharge and termination of services. Richmond Behavioral Health Authority does not directly operate any of the services in Articles 1, 2 or 3. (Please see Appendix B for Service Descriptions and Job Descriptions)

Article 1 Opioid Treatment Services

Article 2 Social Detoxification Services

Article 3 Services in Department of Corrections Correctional Facilities

Sponsored Residential Home Services

12 VAC 35-105-1160 Sponsored Residential Home Information

Richmond Behavioral Health Authority shall ensure that the following information is maintained on all contracted providers of sponsored residential home services:

1. Names and ages of residential sponsors
2. Date of sponsored residential home agreement
3. The maximum number of individuals that can be placed in the home;
4. Names and ages of all other individuals not receiving services, but residing in a sponsored residential home;
5. Address and telephone number of the sponsored residential home; and
6. All staff employed in the home, including on-call and substitute staff

12 VAC 35-105-1170 Sponsored Residential Home Agreements

Richmond Behavioral Health Authority shall maintain written agreements with all residential home sponsors who provide the home where the service is located and are directly responsible for the provision of services. The agreement shall:

1. Be available for inspection by the licensing specialist, and
2. Include a provision for granting the right of entry to state licensing specialists or human rights advocates to investigate complaints

12 VAC 35-105-1180 Sponsor Qualification and Approval Process

Richmond Behavioral Health Authority shall:

- A. Evaluate sponsored residential homes through face to face interviews, home visits, and other information before individuals are placed in the home
- B. Certify that all sponsored residential homes meet the criteria for physical environment and residential services designated in these regulations
- C. Document the sponsored staff's ability to meet the needs of the individuals placed in the home by assessing and documenting:
 - The sponsored staff's ability to communicate and understand individuals receiving services
 - The sponsored staff's ability to provide the care, treatment, and training or habilitation for individual receiving the services in the home
 - The abilities of all members of the household to accept individuals with disabilities and their disability-related characteristics, especially the ability of children in the household to adjust to non-family members living with them; and
 - The financial capacity of the sponsor to meet the sponsor's own expenses for up to 90 days, independent of payments received for residents living in the home
- D. Richmond Behavioral Health Authority will closely monitor to ensure that sponsors obtain references, criminal background checks and a search of the registry of founded complaints of child abuse and neglect maintained by the Department of Social Services for all adults in the home who are staff. Richmond Behavioral Health Authority shall request that contractors provide references, background and registry checks for all adults in the home who are not staff and not the individuals being served, when appropriate.
- E. All sponsored residential home members shall submit the results of a physical and mental health examination based on indications of a physical or mental health problem, upon request from Richmond Behavioral Health Authority.
- F. Richmond Behavioral Health Authority shall require that sponsored residential homes shall not also operate as group homes or Department of Social Services approved or foster homes.

12 VAC 35-105-1190 Sponsored Residential Home Service Policies

- A. Richmond Behavioral Health Authority (RBHA) staff shall provide orientation at the time of placement and provide ongoing supportive services to sponsored staff specific to individual receiving services.
- B. The RBHA staff coordinating a placement with residential sponsors shall provide sponsored staff training that is consistent with resident needs.
- C. RBHA staff shall specify staffing arrangements in all homes, including on-call and substitute care.
- D. RBHA staff will manage, monitor, and supervise sponsored residential homes through site visits and/or telephone contacts, as necessary.
- E. RBHA staff shall conduct at least semi-annual unannounced visits to sponsored residential homes.
- F. On an ongoing basis and at least annually, RBHA staff review compliance of sponsored residential homes and sponsors with regulations related to sponsored residential homes. RBHA will conduct said activities by means considered to be the least disruptive to program services.
- G. If it appears that a violation of the resulting agreement with the residential sponsors has occurred or if it is found that the residential services are not being delivered as agreed upon in the terms and conditions of the agreement other than approved by the RBHA and the program resolution has not occurred between RBHA staff and the sponsor, the following action will take place:
 - The Division Director will report findings to the Executive Director and make recommendations regarding necessary actions
 - After a review of the situation, the Executive Director/or designee will determine who will communicate his/her findings to the sponsor stipulating required action and the time frames for such action
 - Within ten (10) working days after the receipt of said communication, the sponsor will send a “Plan of Action” to the Executive Director/ or designee for review and approval.
 - Once approved, said “Plan of Action” will be monitored by the designated RBHA staff to ensure implementation within the specified time frames. If the plan is successful, no further action will be required. If the “Plan of Action” is not successful within the specified time frames, the sponsor will be in violation of the agreement.
 - RBHA may terminate said agreement by giving thirty (30) days notice. The agreement will be terminated 30 days from the receipt of notice by the sponsor.

12 VAC 35-105-1200 Supervision

Richmond Behavioral Health Authority requires that all sponsored residential providers adhere to the following guidelines:

- A. A responsible adult shall be available to provide supervision to the individual as specified in the individualized service plan
- B. Any member of the sponsor family who transports individuals receiving services must have a valid driver’s license and automobile liability insurance. The vehicle used to transport individuals receiving services shall have a valid registration and inspection sticker.

- C. The sponsor shall inform RBHA in advance of any anticipated additions or changes in the home or as soon as possible after an unexpected change occurs.

12 VAC 35-105-1210 Sponsored Residential Home Service Records

All RBHA providers of sponsored residential home services shall maintain records on each sponsored residential home, which shall include:

1. Documentation of references
2. Criminal background checks and results of the search of the registry of founded complaints of child abuse and neglect of all adults who are staff in the home
3. Orientation and training provided by RBHA
4. A log of RBHA visits to each sponsored residential home including the date, the staff person visiting, the purpose of the visit, and significant events
5. A log of significant events related to individuals receiving services

12 VAC 35-105-1220 Regulations Pertaining to Employees

Richmond Behavioral Health Authority will certify compliance of sponsors with regulations pertaining to employees.

12 VAC 35-105-1230 Maximum Number of Beds or Occupants in Sponsored Residential Home

Richmond Behavioral Health Authority will adhere to licensure regulations as it relates to the maximum number of sponsored residential home beds as follows:

- The maximum number of beds is two (2)
- The maximum number of occupants is seven (7)

Case Management Services

12 VAC 35-105-1240 Service Requirements for Providers of Case Management Services

- A. As part of the intake assessment and a provider of case management services, RBHA shall identify individuals whose needs may be addressed through case management services.
- B. All documentation of case management services shall be performed consistent with the individual's assessment and individualized services plan to include:
 1. Enhancing community integration through increased opportunities for community access and involvement; and creating opportunities to enhance community living skills to promote community adjustment including to the maximum extent possible, the use of local community resources available to the general public
 2. Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's individualized services plan and his community adjustment

3. Assessing needs and planning services to include developing a case management individualized service plan
4. Linking the individual to those community supports that are likely to promote the personal habilitative/rehabilitative and life goals of the individual as developed in the individualized service plan (ISP)
5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits
6. Assuring the coordination of services and service planning within a provider agency, with other providers and with other human service agencies and systems, such as local health and social service departments
7. Monitoring service delivery through contacts with individuals receiving services, service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual
8. Providing follow up instruction, education and counseling to guide the individual and develop a supportive relationship that promotes the individualized service plan
9. Advocating for individuals in response to their changing needs, based on changes in the individualized services plan
10. Developing a crisis plan for an individual that includes the individual's references regarding treatment in an emergency situation
11. Planning for transition in individual's lives; appropriately notifying the consumer and authorized representatives of changes in level of services including discharge;
12. Knowing and monitoring the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary and other medical services, as needed

In accordance with the requirements of the Department of Medical Assistance Services (DMAS), the following is not intended to be all inclusive, but are examples of covered services and staff qualifications that must be met:

MR Targeted Case Management and Home/Community-Based MR Waiver Services

1. Assessment and planning services, to include the significant role of the case manager as the team facilitator and who is also primarily responsible for the development of Consumer Service Plan (CSP) and Individualized Service Plan (ISP) for case management services
2. An assessment must be completed by a qualified professional or qualified mental retardation case manager to determine the support needs. This assessment then serves as the basis for the CSP and all ISPs.
3. Document that the choice of a provider has been offered when services are initiated and when there are changes in services
4. Coordinate the comprehensive assessment of the strengths and needs of consumer in major life areas and identify supports and services needed in the community (e.g. complete Consumer Profile/Social Assessment, coordinate-at least annually, the completion or update of relevant assessments; involve support providers and significant others in gathering assessment information)
5. Coordinate the completion and implementation of the Consumer Service Plan

6. Assist in the development of and review all ISPs from providers selected by the consumer
7. A release form must be completed and signed by the consumer and/or authorized representative for the release of any information
8. Link the consumer with appropriate community resources and supports, and coordinate with personnel of other agencies as specified in ISP; complete any needed referrals to newly identified services
9. Monitor all services and on-going services to ensure the identified supports being delivered meet the needs and satisfaction of the individual and revise CSP as needed
10. Complete at least one activity monthly with/for the consumer (i.e. phone calls, correspondence, visits, to ensure/obtain needed supports (as related to the assessment)
11. At least quarterly (90 days), meet and review with consumer/significant others, supports being provided; satisfaction with services; and to identify any changes or additions requested by the consumer
12. Complete at least monthly case documentation of activities; quarterly reviews of services provided, documentation of visits/meetings with the consumer, and collateral contacts
13. Appropriately notifying the consumer and authorized representative in writing (within 10 days) about changes in level of services or discharge and their right to appeal to DMAS. ***For applicants and recipients whose primary language is not English, a translation understood by the applicant or recipient of the appeal rights must be included.***

Qualifications of Providers for Targeted MR Case Management Services

For Targeted MR Case Management services to receive Medicaid reimbursement, the individual employed as a Case Manager must possess a combination of mental retardation work experience and relevant education, and at a minimum, qualifications that documented or observable to include:

- A. Knowledge of:
 - The nature and causes of mental retardation and program philosophy for service provision
 - Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination
 - Different types of assessments, including functional assessment, and their uses in service planning
 - Human rights
 - Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communications, recreation, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups);
 - Types of mental retardation programs and services

- Effective oral, written, and interpersonal communication principles and techniques
- General principles of record documentation
- The service planning process and major components of a service plan

1. Skills in:

- Interviewing; negotiating with individuals and service providers; observing, recording, and reporting on an individual's functioning;
- Identifying and documenting on individual's need for resources, services and other supports; using information from assessments, evaluations, observation and interviews to develop service plans;
- Identifying services within the community and established service system to meet the individual's needs; formulating, writing and implementing individualized service plans to promote goal attainment; coordinating the provision of services by diverse public and private providers;
- Identifying community resource and organizations and coordinating resources and activities; using assessment tools (e.g. level of function scale, life profile scale)

B. Abilities to:

- Be persistent and remain objective; work as a team member, maintaining effective inter- and intra-agency working relationships;
- Demonstrate a positive regard for individuals and their families (e.g. treating people as individuals, allowing risk-taking, avoiding stereotyping of people with mental retardation, respecting individuals' and families privacy, and believing individuals are valuable members of society)
- Work independently performing position duties under general supervision; communicate effectively, verbally and in writing; establish and maintain ongoing supportive relationships

MH Case Management Services

1. For case management services, specific objectives in the ISP for monitoring, linking, and coordinating must be included and those services/activities in **bold** must be provided.
2. **Assessment and planning** services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such assessment); an assessment must be completed by a qualified mental health case manager to determine the need for services which serves as the basis for the ISP
3. The referral/preliminary assessment information must be documented in the clinical record and based on a face to face contact with the consumer; the assessment and subsequent reassessments of the individual's medical, mental, and social status must be reflected with appropriate documentation; the initial preliminary comprehensive assessment must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment; an assessment of adaptive functioning is recommended to support medical necessity criteria

4. Appropriately notifying the consumer and authorized representative in writing (within 10 days) about changes in level of services or discharge and their right to appeal to DMAS.

For applicants and recipients whose primary language is not English, a translation understood by the applicant or recipient of the appeal rights must be included.

5. Document that the choice of a provider has been offered when services are initiated and when there are changes in services
6. The preliminary ISP must document the need for case management and be fully completed within 30 days of the initiation of the service, and the case manager must review the ISP every three months and rewrite annually; the review will be due by the last day of the third month in which the last review was due and not on the date when the review was actually completed in the grace period. A grace period will be granted up to the last day of the fourth month following the month the review was due, however all RBHA staff are required to complete and submit reviews by the last day of the third month
7. The ISP must be comprehensive and regularly updated; specific to the individual being treated; contain treatment/training needs, goals and measurable objectives to meet identified needs, services to be provided with recommended frequency to accomplish the measurable goals and objectives; estimated timetable for achieving the goals and objectives; the person responsible for the service intervention; maintained up to date as needs and progress of individual changes
8. Mandatory monthly case management contact, activity, or communication relevant to the ISP; written plan development, review, or other written work is excluded
9. A release form must be completed and signed by the consumer and/or authorized representative for the release of any information
10. **Linking** the individual to services and supports specified in the ISP; provide services in accordance with the ISP; **assisting the individual directly**, which may include transportation for the purpose of developing or obtaining needed resources, including crisis assistance supports
11. **Coordinating services** and treatment planning with other agencies and providers
12. There must be an ISP from each provider rendering services to the consumer
13. The ISP shall be updated at least annually; there must be no more than 365 days between the effective dates of a consumer's annual ISP; the case manager must revise the ISP whenever the amount, type or frequency of services rendered by the case manager change and involve the consumer in the discussion of the need for the change
14. Document progress to convey consumer's status, staff interventions and as appropriate, progress towards goals and objectives in the plan of care; documentation must include name of service rendered, date service rendered, signature and credentials of person rendering service, amount of time required to deliver the service
15. **Enhancing community integration** through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment
16. **Making collateral contacts** with significant others to promote implementation of the service plan and community adjustment
17. **Monitoring** service delivery through contacts with service providers as well as periodic site visits and home visits

18. **Education and counseling** which guide the consumer and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. Case Management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's capacity in the community; ***educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific consumers (e.g. group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities)***

Qualifications of Providers for MH Case Management Services

RBHA may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers or qualified mental health professional (QMHP). This individual is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis. A more comprehensive description of the DMAS qualifications is outlined in Chapter 2, page 5 of the Community Mental Rehabilitative Services Manual. The minimal qualifications include:

1. A bachelor's degree, from an accredited college in an unrelated field with an associate's degree in a human service field and who has at least three years clinical experience in social work, gerontology, psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation, and human service counseling
2. Knowledge of:
 - Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs
 - The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues
 - Different types of assessments, including functional assessment, and their uses in service planning
 - Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination
 - The service planning process and major component of a service plan
 - The use of medications in the care or treatment of the population served
 - All applicable federal and state laws, regulations, and local ordinances
3. Skills in:
 - Identifying and documenting an individual's needs for resources, services, and other supports; using information from assessments, evaluations, observation, and interviews to develop individual service plans
 - Identifying services and resources within the community and establish services systems to meet the individual's needs, and documenting how resources, services and natural supports, such as family, can be utilized to achieve an individual's personal habilitative/rehabilitative, and life goals
 - Coordinating the provision of services by public and private providers

4. Abilities to:

- Work with team members, maintaining effective inter- and intra-agency working relationships; work independently, performing position duties under general supervision; engage and sustain ongoing relationships with individuals receiving services

12 VAC 35-105-1250 Qualifications of Case Management Employees or Contractors

A. RBHA staff providing case management services shall have knowledge of:

1. Services and systems available in the community including primary health care, support services, eligibility criteria and intake processes and generic community resources
2. The nature of serious mental illness, mental retardation and/or substance abuse depending on the population served, including clinical and developmental issues
3. Different types of assessments, including functional assessment, and their uses in service planning
4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination
5. Types of mental health, mental retardation and substance abuse programs available in the locality; the use of medications in the care or treatment of the population served; all applicable federal and state laws, state regulations and local ordinances

B. RBHA staff shall have skills in:

1. Identifying and documenting an individual's need for resources, services, and other supports; using information from assessments, evaluations, observation, and interviews to develop service plans
2. Identifying and documenting how resources, services and natural supports such as family can be utilized to promote achievement of an individual's personal habilitation/rehabilitative and life goals
3. Coordinating the provision of services by diverse public and private providers

C. RBHA staff shall have abilities to:

1. Work as team members, maintaining effective inter- and intra-agency working relationships; work independently performing position duties under general supervision; engage and sustain ongoing relationships with individuals receiving services

Community Gero-Psychiatric Residential Services

12 VAC 35-105-1260 through 12 VAC 35-105-1350

The Richmond Behavioral Health Authority does not operate Community Gero-Psychiatric Residential Services.

Intensive Community Treatment and Program of Assertive Community Treatment Services

(Please see Appendix A for Service Description)

12 VAC 35-105-1360 Admission and Discharge Criteria

- A.** All individuals referred to Richmond Behavioral Health Authority for ICT and PACT services must meet the following admission criteria:
- Severe and persistent mental illness, predominantly schizophrenia, other psychotic disorder, or bipolar disorder that seriously impairs functioning in the community. Individuals with a sole diagnosis of substance addiction or abuse or mental retardation are not eligible for services
 - Impairments on a continuing or intermittent basis without intensive community support to include one or more of the following:
 1. Inability to consistently perform practical daily living tasks required for basic adult functioning in the community
 2. Persistent or recurrent failure to perform daily living tasks except with significant support of assistance by family, friends, or relatives
 3. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out homemaker roles
 4. Inability to maintain a safe living situation
 - High service needs due to one or more of the following problems:
 - a. Residence in a state mental health facility or other psychiatric hospital but clinically assessed to be able to live in a more independent situation if intensive services were provided or anticipated to require extended hospitalization, if more intensive services are not available
 - b. High user of state mental health facility or other acute psychiatric hospital inpatient services within the past two years or a frequent user of psychiatric emergency services (more than four times per year)
 - c. Intractable (i.e. persistent or very recurrent) severe major symptoms such as affective, psychotic, suicidal)
 - d. Co-occurring substance addiction or abuse of significant duration (e.g. greater than six months)
 - e. High risk or a recent history (within the past six months) of criminal justice involvement (e.g. arrest and incarceration)
 - f. Unable to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless
 - g. Unable to consistently participate in traditional office-based services
- B.** PACT individuals should not be discharged for failure to comply with treatment plans or other expectations of RBHA, except in certain circumstances as outlined. Individuals must meet at least one of the following criteria to be discharged:
- Moving out of the service area
 - Death
 - Incarceration for a period to exceed a year or hospitalization for than one year

- Choice of the individual (RBHA staff is responsible for revising the individualized services plan to meet any concerns of the individual leading to the choice of discharge
- Demonstration by the individual of an ability to function in all major role areas with minimal team contact and support for at least two years as determined by both the individual and ICT or PACT team

12 VAC 35-105-1370 Treatment Team and Staffing Plan

A. ICT and PACT Services are delivered by Interdisciplinary teams

- Eighty percent of RBHA staff on ICT team shall meet the qualifications of QMHP, who are qualified to provide the services described in 12 VAC 35-105-1410 to include at least five full-time equivalent clinical staff. At least ten full-time equivalent clinical staff shall be on RBHA's PACT team to include a program assistant and a full or part-time psychiatrist. Additionally, the team shall include the following positions:
 1. Team Leader – one full time equivalent (FTE) QMHP with three years experience in the provision of mental health services to adults with serious mental illness
 2. Nurses – one or more FTE registered nurse with one year of experience or licensed practical nurse with three years of experience in the provision of mental health services to adults with serious mental illness
 3. Mental Health Professionals – two or more FTE QMHPs (half of whom shall hold a master's degree), including a vocational specialist and a substance abuse specialist
 4. Peer Specialists – one or more FTE QPPMH or QMHP who is or has been a recipient of mental health services for severe and persistent mental illness
 5. Program assistant – one person with skills and abilities in medical records management, operating and coordinating the management information system, maintaining accounts and budget records for individual and program expenditures, and providing receptionist activities. **(Please note that RBHA has Medical Records and MIS Departments)**
 6. Psychiatrist – one board certified or board eligible in psychiatry and licensed to practice medicine. An equivalent ratio to 20 minutes (.008 FTE) of psychiatric time for each individual served must be maintained
- In addition, a PACT team includes at least three FTE nurses (at least one of whom is an RN and five or more mental health professionals

B. ICT and PACT teams must include a minimum number of employees (counting contractors but not counting the psychiatrist and program assistant) to maintain an employee to individual ratio of at least 1:10. ICT Teams may serve no more than 80 individuals. PACT teams may serve no more than 120 individuals. A transition plan will be required of PACT teams that will allow for "start up" when teams are not in full compliance with the PACT model relative to staffing patterns and client capacity

C. ICT and PACT teams shall meet daily Monday through Friday or at least four days per week to review and plan services and to plan services and to plan for emergency and crisis situations.

- D. ICT teams shall operate a minimum of 8 hours per day, 5 days per week and shall provide services on a case by case basis in the evenings and on weekends. PACT teams shall be available to individuals 24 hours per day and shall operate a minimum of 12 hours each weekday and 8 hours each weekday and each holiday.
- E. The ICT and PACT team shall make crisis services directly available 24 hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily. The PACT team shall operate an after-hours on-call system and be available by telephone or in person.

12 VAC 35-105-1390 ICT and PACT Service Daily Operation and Progress Notes

- A. The ICT teams and PACT teams shall conduct daily organizational meetings Monday through Friday at a regularly scheduled time to review the status of all individuals and the outcome of the most recent staff contact, assign daily and weekly tasks to staff, revise treatment plans as needed, plan for emergency and crisis situations, and to add service contacts that are identified as needed.
- B. A daily log that provides a roster of individuals served in the ICT or PACT services program and documentation of services provided and contacts made with them shall be maintained. There shall also be at least a weekly individual note documenting progress or lack of progress toward goals and objectives as outlined in the Psychosocial Rehabilitation Services Plan.

12 VAC 35-105-1400 ICT and PACT Assessment

RBHA staff shall solicit the individual's own assessment of his needs, strengths, goals, preferences and abilities to identify the need for recovery oriented treatment, rehabilitation and support services and the status of his environmental supports within the individual's cultural context. RBHA staff will assess:

- A. Psychiatric history, mental status and diagnosis, including the content of an advance directive
- B. Medical, dental and other health needs
- C. Extent and effect of drug or alcohol use
- D. Education and employment including current daily structures use of time, school or work status, interests and preferences and the effect of psychiatric symptomatology on educational and employment performance
- E. Social development and functioning including childhood and family history, culture and religious beliefs, leisure interests and social skills
- F. Housing and daily living skills, including the support needed to obtain and maintain decent, affordable housing integrated into the broader community; the current ability to meet basic needs such as personal hygiene, food preparation, housekeeping, shopping, money management and the use of public transportation and other community based resources

- G. Family and social network including the current scope and strength of an individual's network of family, peers, friends, and co-workers and their understanding and expectations of the team's services
- H. Finances and benefits including the management of income, the need for and eligibility for benefits and the limitations and restrictions of those benefits
- I. Legal and criminal justice involvement including the guardianship, commitment, representative payee status and the experience as either victim or accused person

12 VAC 35-105-1410 Service Requirements

RBHA staff shall document that the following services are provided consistent with the individual's assessment and individualized services plan:

- A. Ongoing assessment to ascertain the needs, strengths and preferences of the individual
- B. Case management
- C. Nursing
- D. Symptom assessment and management
- E. Psychopharmacological treatment, administration and monitoring
- F. Substance abuse assessment and treatment for individuals with a dual diagnosis of mental illness and substance abuse
- G. Individual supportive therapy
- H. Skills training in activities of daily living, social skills, interpersonal relationships and leisure time
- I. Supportive in-home services
- J. Work-related services to help find and maintain employment
- K. Support for resuming education
- L. Support, education, consultation, and skill-teaching for family members and significant others
- M. Collaboration with families and assistance to individuals with children
- N. Direct support to help individuals obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community
- O. Mobile crisis assessment, intervention and facilitation into and out of psychiatric hospitals

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