

INCOMPLETE DISCUSSION DRAFT



STATE OF ALASKA
Department Of Health & Social Services
CMH/API 2000 Project
2900 Providence Drive
Anchorage, Alaska 99508

Request For Grant Proposals

Anchorage Program for Assertive Community Treatment (PACT)

A request for proposals for grant funding to provide a Program for Assertive Community Treatment (PACT) to serve residents in the Anchorage area and adhering to the model and standards approved by the National Alliance for the Mentally Ill (NAMI).

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ATTACHMENT: PACT Budget Estimates: Average utilization of 80 clients.

Incomplete Discussion Draft

**Request for Grant Proposals
Anchorage Program for Assertive Community Treatment**

Goals of the Program for Assertive Community Treatment

The goal of the Anchorage Program for Assertive Community Treatment, PACT, is to increase the capacity of the Anchorage community-based mental health system by adding a new program to provide intense, ongoing, outpatient services to persons with chronic and severe mental illness. The purpose of adding another level of intensity in ongoing care to the existing array of mental health services in Anchorage is two fold: (1) to respond to the request of consumers and consumer advocates for greater diversity in mental health services, and for pursuit of the PACT in particular, and (2) to further reduce the reliance of the Anchorage community on Alaska Psychiatric Institute (API). The PACT will provide ongoing, multi-disciplined services to an average of 80 people with chronic and severe mental illness, complicated for many by substance abuse. This new program is to target Anchorage residents who would otherwise constitute the highest demand for API acute psychiatric care services as measured by inpatient days.

The addition of the PACT is intended to increase the overall effectiveness of the Anchorage community mental health services system in reducing the total number of acute care inpatient days attributable to residents of Anchorage referred to as the “high users group,” those who spend 30 days or more in the API acute care units over the course of a year. The goal is to cut by half or more the inpatient acute care demand attributable to the high users group, a reduction of at least 4,000 patient days from the average of about 8,000 patient days per year attributable to high users from 1995 through 1999, or the equivalent of about 12 acute care beds. This goal implies a reduction in the number of people in the high users group, averaging about 96 per year over the last five years, and in the average number of inpatient days experienced per person, averaging about 83 days per year for the same period.

The Anchorage PACT is to follow *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up* and to adhere to The NAMI Recommended PACT Standards for New Teams, as incorporated into this RFGP.

Eligibility (Who may apply)

Eligible applicants include private nonprofit corporations capable of serving residents of the Anchorage area.

Duration of Grant

This RFP is for a grant period of 18 months, starting January 1, 2001 through June 30, 2002. This includes a 3-month start-up period. At the discretion of the Department of Health and Social Services, a program funded under this RFGP may be considered for continued funding for a subsequent program period, July 1, 2002 through June 30, 2004.

Program Funding

The Department of Health and Social Services is funding the first 18 months of this program with a federal grant to the Department administered by the Substance Abuse and Mental Health Services Administration, SAMHSA. Program funding subsequent to June 30, 2002 will require that the Alaska State Legislature appropriate Mental Health General Funds specifically for this purpose.

The Department will make grant funds available to reimburse the grantee for the amount of approved program service delivery costs that exceed program receipts from self pay and third-party payers, including Medicaid. The program is estimated to cost the Department \$714,000 in total funding for the grant period of which \$283,000 is estimated to be required for the 3-month start-up period and \$431,000 is estimated to be required for 16 months of operation during the grant period (see PACT Budget Estimate, attached).

This funding amount is based on the assumption that the grantee will serve an average of 80 clients over the 16-month operating period of whom 60 percent will be Medicaid eligible and 15 per cent will be Medicare eligible resulting in collections estimated at about \$1,080,000 in Medicaid reimbursements and about \$297,800 in Medicare reimbursements.

Scope of Services

I. Introduction

- A. The Program of Assertive Community Treatment (PACT) is to be a self-contained clinical team that does the following:
1. assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified clients with severe and persistent mental illnesses, complicated for many by substance abuse;
 2. minimally refers clients to outside service providers;
 3. provides services on a long-term care basis with continuity of caregivers over time;

4. delivers 75 percent or more of the services outside program offices; and
5. emphasizes outreach, relationship building, and individualization of services.

The clients to be served are Anchorage residents who are either high users¹ of API acute care services at the time of referral or are likely to become high users, if they do not receive PACT services. These include individuals who have severe symptoms and impairments not effectively remedied by available treatments or who, because of reasons related to their mental illnesses, resist or avoid involvement with mental services and have difficulties maintaining safe and reliable housing.

The PACT team leader, program psychiatrist, program assistant, and multidisciplinary staff are to ensure service excellence and courteous, helpful, and respectful services to program clients. Their goal is to substantially reduce each client's need for acute inpatient care. There should be no more than 10 clients to one staff member.

II. Admission and Discharge Criteria

A. Admission Criteria

All admissions to the PACT program will be selected from referrals from the PACT referral committee appointed by the Director of DMHDD and chaired by a representative of DMHDD and including clinical staff and social services professionals. The referral committee will consult with the individual, the individual's guardian, if one has been appointed, family members and members of the individual's natural support system, as identified and consented to by the individual, and the individual's most recent housing and community services provider(s), upon retaining permission for the release of information from the individual.

The following criteria are to be used by the committee in referring clients in the greatest need of PACT services because the committee believes the individual will continue to be or will soon become a high user of API acute care services, if they do not receive PACT services:

1. Clients to be served are Anchorage residents, or people willing to become Anchorage residents, with severe and persistent mental illnesses listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric

¹ Requiring 30 days or more within a year of inpatient, hospital care over the course of one or more admissions.

Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder because these illnesses more often cause long-term psychiatric disability. (Individuals with a primary diagnosis of a substance use disorder or mental retardation are not appropriate.)

2. Clients with significant functional impairments as demonstrated by at least one of the following conditions:
 - a. inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions) or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives;
 - b. inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities); or
 - c. inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

3. Clients with one of more of the following problems, which are indicators of continuous high-service needs:
 - a. high use of acute psychiatric hospitals or psychiatric emergency services;
 - b. intractable (i.e., persistent or very recurrent), severe major symptoms (e.g., affective, psychotic, suicidal);
 - c. coexisting substance use disorder of significant duration (e.g., greater than six months);
 - d. high risk or recent history of criminal justice involvement (e.g., arrest and incarceration);
 - e. inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless;

- f. residing in an inpatient bed or in a 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; or
- g. inability to participate in traditional office-based services.

B. Discharge Criteria

1. Discharges from the PACT team occur when clients and program staff mutually agree to the termination of services. This shall occur when clients do one or more of the following:
 - a. move outside the Municipality of Anchorage; (The PACT team shall arrange for transfer of mental health service responsibility to a provider wherever the client is moving. The PACT team shall maintain contact with the client until this service transfer is arranged);
 - b. demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without minimal or no assistance from the program for at least two years, with this determination to be made by both the client and the PACT team; or
 - c. request discharge, despite the team's best efforts to develop a treatment plan acceptable to them.
2. Documentation of discharge shall include the following:
 - a. the reasons for discharge;
 - b. the client's status and condition at discharge;
 - c. a written final evaluation summary of the client's progress toward the goals set forth in the treatment plan;
 - d. a plan developed in conjunction with the client for treatment after discharge and for follow-up;
 - e. verification of follow-up by any provider(s) identified in the discharge plan; and
 - f. the signature of the client, client's primary case manager, team leader, and psychiatrist.

Policy and Procedure Requirements: The PACT team shall maintain written admission and discharge policies and procedures.

III. Service Capacity

The PACT team shall have the organizational ability to provide service to an average of 80 clients with a staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every ten clients (excluding the psychiatrist and the program assistant), with no more than 120 clients served.

IV. Staff Requirements

The PACT team shall have among its staff individuals qualified to provide the services described in Section VIII, including case management; crisis assessment and intervention; symptom assessment and management; individual supportive therapy; medication prescription, administration, monitoring, and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that clients obtain the basic necessities of daily life; and education, support, and consultation to clients' families and other major supports.

The PACT provider shall employ a minimum of 10 to 12 FTE clinical staff persons, one program assistant, and a psychiatrist's time of at least 16 hours per week for every 50 clients on the team.

The following minimum staffing configuration must be met by the PACT team:

- A. A full-time team leader/supervisor, who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the PACT team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation, or psychology, or is a psychiatrist.
- B. A psychiatrist on a full-time or part-time basis for a minimum of 16 hours per week for every 50 clients. The psychiatrist provides clinical services to all PACT clients, works with the team leader to monitor each client's clinical status and response to treatment, supervises staff delivery of services, and directs psychopharmacologic and medical treatment.
- C. A minimum of eight to 10 FTE mental health professionals (including the team leader). These mental health professionals will have professional degrees in one of the core mental health disciplines, clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting, and clinical work experience with persons with severe and persistent mental illnesses. They are licensed or certified

per the regulations of the state of Alaska. Mental health professionals include persons with master's or doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; diploma-, associate-, and bachelor's nurses (i.e., registered nurses) and registered occupational therapists.

Required among the mental health professionals are the following:

1. at least three FTE registered nurses (a team leader with a nursing degree cannot replace one of these FTE nurses); and
 2. one or more staff mental health professionals designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling.
- D. Remaining clinical staff may be bachelor's-level and paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's-level mental health worker has a bachelor's degree in a behavioral science and work experience with adults with severe and persistent mental illnesses. A paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and has work experience with adults with severe and persistent mental illnesses or with individuals with similar human-services needs. These paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.
- E. A minimum of one FTE peer specialist. The peer specialist is to be someone who is or has been a recipient of mental health services for severe and persistent mental illness. Because of her or his life experience with mental illness and mental health services, the peer specialist is expected to provide expertise that professional training cannot replicate. The peer specialist is to be a fully integrated team member who provides highly individualized services in the community and promotes client self-determination and decision-making. The peer specialist also provides essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities. A peer specialist who also meets the mental health professional qualifications should be compensated accordingly.
- F. A program assistant (one to one and a half FTE) who is responsible for organizing, coordinating, and monitoring all operations of PACT that are not clinical in nature including managing medical records; operating and coordinating the management information system; maintaining accounting

and budget records for client and program expenditures; maintaining records and preparing billings for Medicaid and other third party payers; and providing receptionist activities including triaging calls and coordinating communication between the team and clients.

Policy and Procedure Requirements: The PACT team shall maintain written personnel policies and procedures and shall maintain personnel files for each team member, containing job applications, copies of credentials or licenses, job descriptions, annual performance appraisals, and orientation and training plan.

V. Program Organization

The team leader shall be responsible for ensuring that the PACT team meets the following organizational requirements:

A. Hours of Operation and Staff Coverage

1. The PACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week, over two eight-hour shifts, and operate a minimum of 12 hours per day on weekdays and eight hours each weekend day and every holiday.
2. The PACT team operates an after-hours on-call system. PACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person, including being available to assist clients being discharged from inpatient care.
3. Psychiatric backup shall also be available during all off-hours periods provided primarily by the PACT team psychiatrist. When availability of the PACT team's psychiatrist is not feasible, the team psychiatrist will arrange for and coordinate with alternative psychiatric backup.

Policy and Procedure Requirements: The PACT team shall maintain written policies and procedures for ensuring continuity in psychiatric care delivered to the client when psychiatric backup care is required.

B. Service Intensity

1. The PACT team shall have the capacity to provide multiple contacts per week to clients experiencing severe symptoms or significant problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week, depending on client need. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contacts.

2. The PACT team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it.
3. The PACT team shall provide an average of no less than three contacts per week for all clients.

C. Place of Treatment

The PACT team shall provide 75 percent of service contacts in the community, outside an office and outside service facility settings. The PACT provider will maintain data to verify this goal is being met.

D. Staff Communication and Planning

1. The PACT 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:
 - a. The PACT team will maintain a written daily log. The daily log will provide the following:
 - i. a roster of the clients served in the program, and
 - ii. for each program client, brief documentation of any and all treatment or service contacts that have occurred during the day and a concise, behavioral description of the client's daily status.
 - b. The daily organizational staff meeting will commence with a review of the daily logs, to update staff on the treatment contacts that occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all clients.
 - c. The PACT team, under the direction of the team leader, shall maintain a weekly client schedule for each client. The weekly client schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the client's treatment plan. A central file of all weekly client schedules will be maintained by the team.
 - d. The PACT team, under the direction of the team leader, shall develop a daily staff assignment schedule from the central file of

all weekly client schedules. The daily staff assignment schedule is a written timetable for all client treatment and service contacts, to be divided and shared by the staff working on that day.

- e. 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.
 - f. At the daily organizational staff meeting, the PACT team will also discuss revisions to treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.
2. The PACT team shall conduct person-centered services planning meetings under the supervision of the team leader and the psychiatrist. These services planning meetings shall proceed as follows:
- a. Convene at regularly scheduled times and places of the client's choosing per a written schedule maintained by the team leader, and
 - b. Occur with sufficient frequency and duration to develop written individual client treatment plans following the principals of person-centered planning and to review and rewrite the plans every six months.

E. Staff Supervision

Each PACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader, or his or her clinical staff designee, or both shall assume responsibility for supervising and directing all PACT team staff activities. Clinical supervision provided to PACT team staff shall be documented in writing. This supervision and direction shall consist of the following:

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

2. Participation with team members in daily organizational staff meetings and regularly scheduled treatment planning meetings, as described in Section VI.D., to review and assess staff performance and provide staff direction regarding individual cases; and
3. Regular meetings with individual staff to review cases, assess performance, and give feedback. Clinical supervision provided to PACT team staff shall be documented in writing in either client or staff files, as appropriate.

Policy and Procedure Requirements: The PACT team shall maintain written program organization policies and procedures including required hours of operation and coverage, service intensity, staff communication and planning, emphasis on team approach, and staff supervision, as outlined in this section.

VI. Assessment and Services Planning

A. Initial Assessment

An initial assessment and individual plan for services based on the principles of person-centered planning shall be done at the time of the client's admission to PACT by the team leader or the psychiatrist, with participation of the client, the client's guardian, if appointed, and the client's chosen family and natural support system members, and designated team members. If it is not possible to arrange for all participants of the client's choosing to attend the initial planning meeting upon the client's admission to the program, a temporary individual plan for services will be developed by the team leader or psychiatrist, designated team members, and the client and the client's guardian.

B. Comprehensive Assessment

A comprehensive assessment shall be initiated and completed within one month after a client's admission according to the following requirements:

1. Each assessment area shall be completed by PACT team staff with skill and knowledge in the area being assessed and shall be based upon all available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, where applicable.
2. The comprehensive assessment shall include an evaluation of the following areas:

- a. psychiatric symptomatology, mental status, and substance use disorder, if any (Using information derived from the evaluation, a psychiatrist or a psychologist shall make a diagnosis listed in the American Psychiatric Association's DSM IV.);
 - b. psychiatric history, including the client's reporting of their experience of their mental illness and tools they have employed to manage the symptoms of their mental illness, and their response to symptom management tools recommended for their use by mental health professionals, or that they were required to use involuntarily, including prescribed medications and other psychiatric treatment;
 - c. medical, dental, and other health history and current needs;
 - d. extent of historic and current use and effect of alcohol and other drugs as part of a substance abuse or dependence diagnosis;
 - e. housing situation and activities of daily living (ADL);
 - f. vocational and educational history, desires, and current experience and capabilities;
 - g. extent and effect of criminal justice involvement;
 - h. social history, desires and current experience; and
 - i. recent life events.
3. While the assessment process shall involve the input of most, if not all, team members, the client's psychiatrist, primary case manager, and individual treatment team members, the team leader will assume responsibility for preparing the written assessment and ensuring that a comprehensive person-centered services plan is completed within one month of the client's admission to the program.
 4. The client's psychiatrist, primary case manager, and individual treatment team members will be assigned by the program director within a week of admission. The PACT team will make every effort feasible to base staff member assignments on the client's personal preferences.

C. Individual Plan of Service

Individual plans of service will be developed through the following process and incorporating the principles of person-centered planning:

1. With the client, the PACT team shall evaluate each client's needs, strengths, and preferences and develop an individualized plan of service, which identifies individual needs and problems and the client's personal specific measurable long - and short-term goals along with the specific services and activities that will assist the client to meet those goals and improve his or her opportunity to experience a fulfilling life in the community under his or her own terms. The plan of service shall be developed in collaboration with the client, and guardian, if any, and the client's choice of family members and other persons important to the client.
2. Individual team members are responsible to ensure the client is actively involved in the development of treatment and service goals. With the permission of the client, PACT team staff shall also involve pertinent agencies and members of the client's social network in the formulation of individual plans for services.
3. The client's participation in the development of the individual plan of service shall be documented, including evidence of the following:
 - a. the client was provided with information of his or her right to participate in developing a plan for service;
 - b. the client chose whether or not other persons should be involved, and those identified were involved, in the planning process and in the implementation of the individual plan of service;
 - c. the client chose the places and times to meet, convenient to the client and to the people she or he wanted present;
 - d. the client had choice in the selection of PACT treatment or support services and staff to the maximum extent possible;
 - e. the client's preferences and choices were honored, or, if not, that they were considered and reasons for denying them are documented, including a description of the dispute and appeal process, if evoked, and the resulting outcome; and
 - f. the progress made toward the valued outcomes identified by the client was reviewed and discussed for purpose of modifying the strategies and techniques employed to achieve these outcomes.
4. In addition to the client, guardian, if any, and others of the client's choosing, the following staff should attend the individual services planning meeting: the team leader, the psychiatrist, the primary case manager,

individual treatment team members, and all other PACT team members involved in regular tasks with the client.

5. Each client's individual plan for services shall identify needs and problems, strengths and weaknesses, goals incorporating the client's valued outcomes, and specific, measurable service objectives. The individual plan for services must clearly specify the services and activities being offered to the client to assist the client in meeting their needs and realizing their valued outcomes, and which PACT team members will be providing those services and activities.
6. The following key areas should be addressed in every client's individual plan for services: symptom stability, symptom management and education, housing, ADL, employment and daily structure, family and social relationships, and the client's valued outcomes.
7. If the client is diagnosed with a substance use disorder, each provision of the individual plan for services will address it.
8. The individual plan for services will include a crisis prevention plan developed with the client, the client's guardian, if any, members of the client's family and natural support network of the client's choosing, and the primary case manager, psychiatrist and other PACT team members providing services to the client. The crisis prevention plan will address the following:
 - a. situations and triggers that may lead to or escalate a crisis;
 - b. behaviors that provide clues that the client is going into crisis;
 - c. actions the client can take to help prevent a crisis;
 - d. where and in what manner the client prefers to receive assistance from others, including PACT team members, in preventing or de-escalating a crisis;
 - e. client choices for inpatient or residential care, should it become necessary;
 - f. what the client chooses not to be done, and why;
 - g. individuals who are willing to provide assistance, if the client is in a crisis, with children, pets, bills, and other responsibilities;

- h. client crisis information to be on file with PACT team and at the client's disposal and available to others of the client's choosing -- PACT team crisis phone number, people client instructs to be contacted if crisis occurs, medical illnesses/allergies, medication dosages and dates, pharmacy, native language, physical disabilities, special accommodations needed, primary care physician, treating psychiatrist, insurance coverage, guardian or proxy, Social Security payee;
9. The primary case manager and the individual treatment team will be responsible for coordinating the review and rewriting the service goals and individual services plan whenever there is a major decision point in the client's course of treatment (e.g., significant change in client's condition or in the client's valued outcomes) or at least every six months. The revised individual plan for services shall be based on the results of a planning meeting. Additionally, the primary case manager shall prepare a summary (i.e., individual plan for services review) describing the client's progress, including the client's assessment of their progress, since the last planning meeting and outlining the client's current functional strengths and limitations. The plan and review will be signed or acknowledged by the client, guardian, if any, family members and others of the client's choosing, the primary case manager, individual treatment team members, the team leader, the psychiatrist, and all PACT team members.

Policy and Procedure Requirement: The PACT team shall maintain written assessment and individual services planning policies and procedures incorporating the requirements outlined in this section and principles of person-centered planning and role recovery.

VII. Services to Be Provided

Operating as a continuous treatment service, the PACT team shall have the capability to provide comprehensive, client-centered treatment, rehabilitation, and support services as a self-contained service unit. Services shall minimally include the following:

A. Case Management

A primary case manager will be assigned to each client. The primary case manager will coordinate and monitor the activities of the individual treatment team and has primary responsibility to write the individual plan for services, to provide individual supportive therapy, to ensure immediate changes are made in treatment services as clients' needs change, and to advocate for client rights and preferences. The primary case manager is also the first staff person called on when the client is in crisis and is the

primary support person and educator to the individual client's family and other members of the client's natural support system. Members of the client's individual treatment team share these tasks with the case manager and are responsible to perform the tasks when the case manager is not working.

B. Crisis Assessment and Intervention

The PACT team will be capable of providing immediate response to clients in crisis with crisis assessment and intervention services available 24 hours per day, seven days per week. These services will include telephone and face-to-face contact and constitute a fundamental component of PACT team services. Every effort will be made to address the crisis and stabilize the client where they are, in their home, or at a suitable alternative location, and to avoid unnecessary hospitalization.

The PACT team will interface with the CMHC mobile response team, if and when these services are called by or for a PACT client. Procedures will be in place to allow the PACT staff to be called immediately in such instances and PACT staff will respond to the consumer in lieu of the CMHC mobile team, or with the mobile team, if necessary, to ensure continuity of care for PACT clients.

In responding to a client nearing or in crisis the PACT team will adhere to the client's crisis intervention plan to the greatest extent possible and in the best interest of the client's safety.

C. Services Delivered to Clients While Admitted to Inpatient or Residential Services

The PACT team will have in place policies and procedures for interfacing with inpatient or residential care providers, including Alaska Psychiatric Institute, the crisis treatment center, detoxification and dual diagnosis treatment providers, and medical hospitals to provide the following services during the client's inpatient or residential stay:

1. The PACT case manager will work with the client, and the client's guardian, if any, and the client's chosen family and natural support system members to the greatest extent possible to assist with arrangements for admission to inpatient or residential care with appropriate personnel and accompany the consumer through admission into the facility and to the unit to assist the client in providing clinical information and to become settled in the facility;
2. The PACT team psychiatrist will contact and, to the extent possible, work with the facility psychiatrist in assessing the client's inpatient or

residential care needs and making any changes to the client's psychiatric treatment, including medication and other symptom management tools.

3. Upon receiving the required client consent and release of information, the PACT team will participate in the delivery of care to the client as follows:
 - a. provide facility staff a copy of the individual plan of services and a list of medications prescribed and other recommended symptom management tools;
 - b. participate in inpatient or residential treatment planning with facility staff and involving the client, guardian, if any, family members and members of the client's natural support system as approved by the client;
 - c. visit the client and have contact with inpatient staff at least daily;
 - d. accompany the client on outpatient passes;
 - e. participate in discharge planning and incorporate client needs for follow-up services into the PACT team schedule, including consultation with the PACT psychiatrist;
 - f. accompany the client home or to an aftercare provider upon discharge and help the client to settle in and stabilize; and
 - g. keep client's guardian, if any, and others of client's choosing, informed of the client's status and abreast of aftercare decision-making.

D. Symptom Assessment, Management, and Individual Therapy

Symptom assessment, management, and individual therapy helps clients cope with and gain mastery over symptoms and impairments in the context of adult role functioning. This therapy shall include but not necessarily be limited to the following:

1. ongoing assessment of the client's experience of mental illness symptoms, the client's desires, beliefs and feelings in response to both the experience of mental illness symptoms and symptom management tools;

2. providing the client information regarding his or her illness and the effects and side effects of alternative symptom management tools, including use of prescribed medications, when appropriate;
3. assisting the client to identify the symptoms and occurrence patterns of his or her mental illness and to develop methods (internal, behavioral, or adaptive) to help lessen their effects; and
4. generous psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals and to cope with the stresses of day-to-day living.

E. Symptom Management Recommendations, Including Medication Prescription, Administration, Monitoring, and Documentation

1. The PACT team psychiatrist shall perform the following services in order to assist the client in identifying and using symptom coping and management tools, including medication:
 - a. Confer with the client, and guardian, if any, to develop an understanding of the client's experience of and desires regarding the symptoms of her or his mental illness, including the client's use of and response to symptom management tools, including medication.
 - b. Taking into account item 'a' above, assess each client's mental illness symptoms, experience with symptom management and preferences, and recommend symptom management and coping strategies, including prescribing medication or other psychiatric treatment, as necessary.
 - c. Regularly review and document the client's symptoms of mental illness as well as his or her response to those symptoms and satisfaction with recommended symptom management and coping strategies, including use of prescribed medication;
 - d. Provide the client information specific to them, through the means they are most able to understand, regarding his or her mental illness and symptoms;
 - e. Explore with the client the effects and side effects of alternative symptom management tools and coping strategies, including medication, and explain to the client the basis for the psychiatrist's specific recommendations;

- f. monitor, document, and respond with treatment recommendations to any side effects of symptom coping and management tools the client chooses to employ, including medication;
 - g. Document client issues, problems and concerns regarding the recommended use of medication and other symptom coping and management tools and the efforts of the psychiatrist and other PACT team members to increase the client's satisfaction with symptom management recommendations.
2. All PACT team members shall be kept updated about the medication the client is receiving, including when a client's prescription is changed or their use of medication is known to have changed and be alert to, assess and document the client's mental illness symptoms and behavior in response to medication and medication side effects.
3. The PACT team shall establish medication policies and procedures that identify processes to accomplish the following:
- a. record physician orders;
 - b. order medication;
 - c. arrange for all client medications to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules;
 - d. provide security for medications and set aside a private designated area for set up of medications by the team's nursing staff;
 - e. administer medications to team clients; and
 - f. provide for team members working with a client to be fully informed of the implications of changes in medication prescribed for the client to use in order for all staff members to be alert to any unintended or dangerous results for the client.

F. Provision of Substance Use Management Assistance Services

- A. As needed, confer with client regarding use of drugs not prescribed and of alcohol. If client uses alcohol or drugs not prescribed, identify the reasons the client is choosing to use and the client's desires for future use as a basis for any intervention measures.

B. As needed, provision of substance use management assistance shall include but not be limited to individual and group interventions to assist clients to accomplish the following:

1. identify substance use, effects, and patterns;
2. recognize the relationship between substance use and mental illness and psychotropic medications;
3. develop motivation for decreasing substance use;
4. develop coping skills and alternatives to minimize substance use;
5. achieve periods of abstinence and stability; and
6. assure access to and support client's participation, if they so choose, in substance abuse support groups.

G. Work-Related Services

Work-related services to assist clients in fulfilling their personal goals with regard to finding and maintaining employment in community-based job sites will include but not necessarily be limited to the following:

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;
2. assessment of the effect of the client's mental illness on employment, with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors;
3. development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a desired job;
4. individual therapy to assist clients to identify and cope with the symptoms of mental illness that may interfere with their work performance;
5. on-the-job or work-related crisis intervention; and

6. work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation

H. Activities of Daily Living

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to do the following:

1. carry out personal hygiene and grooming tasks;
2. perform household activities, including house cleaning, cooking, grocery shopping, and laundry;
3. find housing which is safe and affordable (e.g., apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating, procuring necessities (such as telephone, furnishings, linens);
4. develop or improve money-management skills;
5. use available transportation; and
6. have and effectively use a personal physician and dentist .

I. Social, Interpersonal Relationships, and Leisure-Time Skill Training

Services to support social, interpersonal relationships, and leisure-time skill training are to align with assisting the client's pursuit of personal valued outcomes and include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to accomplish the following as they are relevant to the client's personal valued outcomes:

1. improve communication skills, develop assertiveness, and increase self-esteem as necessary;

2. develop social skills, increase social experiences, and where appropriate, develop meaningful personal relationships;
3. plan appropriate and productive use of leisure time;
3. relate to landlords, neighbors, and others effectively; and
4. familiarize themselves with available social, civic, community-building and recreational opportunities and increase their use of such opportunities.

J. Support Services

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life include but are not necessarily limited to the following:

1. medical and dental services;
2. safe, clean, affordable housing;
3. financial support;
4. social services;
5. transportation; and
6. legal advocacy and representation.

K. Education, Support and Consultation to Clients' Families and Other Major Supports

Services provided under this category to clients' families and other natural supports, with client agreement and consent, include the following:

1. education about the client's illness and the role of the family and other natural supporters in the therapeutic process;
2. intervention to resolve conflict; and
3. ongoing communication and collaboration, face-to-face and by telephone, between the PACT team, the family and the client's other natural supporters.

Policy and Procedure Requirement: The PACT team shall maintain written policies and procedures for all services outlined in this section.

VIII. Administrative Functions

A. Service Records

1. For each client, the PACT team shall maintain a treatment and services record that is confidential, complete, accurate, and contains up-to-date information relevant to the services provided to the client's and treatment.
2. The record shall sufficiently document assessments, individual plans for services, and the nature and extent of services provided, such that a person unfamiliar with the PACT team can identify the client's services and treatment needs and services received.
3. The team leader and the program assistant shall be responsible for the maintenance and security of the client records.
4. The client records are to be located at PACT team headquarters and, for confidentiality and security, are to be kept in a locked file.
5. For purposes of confidentiality, disclosure of client records by the PACT team is subject to all the provisions of applicable state and federal laws.
6. All client records shall be available for review by the client, the client's guardian, if any, and family and other individuals identified and permitted by the client.

B. Self-Pay and Third Party Billing

1. The PACT provider will be responsible for maintaining an accurate and up-to-date electronic accounts payable and accounts receivable system, including amounts billed and received for all self payers and third party payers (Medicaid, Medicare and private insurance).
2. The PACT provider will assist clients in their application for third party coverage and document their efforts to pursue all third party resources. These efforts should include, but are not limited to, making appropriate requests for prior authorizations for coverage by third party payers. DMHDD may conduct a review of all billing and claiming activities of the PACT provider to ensure compliance with all required standards.
3. The contractor will provide DMHDD with monthly listings of individuals who have been assisted with applications for third party payer coverage.

C. Financial Management

The PACT team provider will report expenditures and revenue information for the approved budget categories to DMHDD on a monthly basis to support payments of grant funds to the provider to reimburse for program costs remaining after receiving payments from self pay and third party payers. DMHDD and the PACT team grantee will agree to the information to be included in the monthly financial reports and to a report format upon grant award.

Policy and Procedure Requirement: The PACT team shall maintain written medical, billing and receipts records management policies and procedures.

IX. Client Rights

The PACT team shall comply with state and federal client rights requirements.

Policy and Procedure Requirement: The PACT team shall maintain client rights policies and procedures.

X. Performance Improvement and Program Evaluation

- A. The PACT team provider shall have a performance improvement and program evaluation plan that shall include the following:
1. A statement of the program's objectives. The objectives shall relate directly to the program's clients or target population and be approved by DMHDD.
 2. Measurable criteria to be applied in determining whether or not the above objectives are achieved.
 3. Methods for documenting achievements related to the program's stated objectives.
 4. Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
 5. In addition to the performance improvement and program evaluation plan, the PACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, of individual plans for services, of discharge practices, and of other factors that may contribute to effective use of the program's resources.

- B. Utilization management data is an essential component of the ongoing process of monitoring PACT services and evaluating the CMH/API 2000 Project. The PACT provider will be responsible for the maintenance of accurate, electronic data regarding consumer demographic information and PACT service utilization.
1. Data about all services provided by the PACT team, inclusive of all payers, must be reported to DMHDD on a monthly basis. These reports must include patient-specific information including unique identifiers, payer classifications, demographic information, service information, charge and reimbursement data, and outcome data. The PACT provider will summarize the monthly report in an annual (State fiscal year) database report.
 2. DMHDD will work with the provider to develop an acceptable format for these reports including integration of data into the State's Alaska Recipient Outcome Reporting Application (ARORA) system.
 3. The PACT team will cooperate with the data collection and coordination requirements of the CMH/API 2000 Project evaluation team, ACSES, throughout the funding period.

Policy and Procedure Requirement: The PACT team shall maintain performance improvement, program evaluation and utilization review policies and procedures.

XI. PACT Team Oversight Committee

The grant recipient organization will appointment of an oversight committee of community stakeholders with an interest in the success of the PACT program to assist and guide the PACT team and DMHDD management of the PACT grant contract.

- A. The committee will have between 10 to 15 members of which no less than three are consumers and no less than 51 percent are consumers and family members. Other stakeholders represented on the committee may include providers of services for people who are homeless or in need of food, consumer peer support organizations, substance abuse and mental health services providers, criminal justice providers, and public safety officers.
- B. The oversight committee will work to strengthen the PACT team, and to increase team resources and community understanding and support for assertive community treatment.

- C. The oversight committee is independent of, and communicates directly with, DMHDD and PACT team management staff. The grant recipient organization will provide administrative support to the committee.
- D. The oversight committee will provide the following assistance:
1. provide input on team resources, policies, and staff hiring recommendations;
 2. provide a forum for review, problem solving and resolution of issues of general concern to the PACT team, consumers, family members, and other stakeholders;
 3. advise the PACT team on how to make services relevant, collaborative, respectful, and desirable to PACT clients;
 4. promote community understanding of PACT model and goals;
 5. monitor ongoing program evaluation data and make recommendations for improvements;
 6. participate in program assessment;
 7. monitor consumer complaints and consumer rights issues;
 8. advocate for resources, including continued funding.

Policy and Procedure Requirement: The PACT team shall maintain written policies and procedures for providing support and program information to the oversight committee and for responding to oversight committee recommendations.

Definitions

Case Management is an organized process of coordination among the multidisciplinary team to provide a full range of appropriate treatment, rehabilitation, and support services to a client in a planned, coordinated, efficient, and effective manner.

Case Manager is the team member who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the plan for services, to provide individual supportive therapy, to ensure immediate changes are made in the plan for services as clients' needs and valued outcomes change and to advocate for client rights and preferences. The case manager is also the first staff person called on when a client is in crisis and provides primary support and education to the client's family and others in the client's natural

support system. The case manager shares these tasks with other members of each client's individual treatment team, who are responsible to perform them when the case manager is not working.

Client is a person who has completed the admissions process and is receiving services from the PACT team.

Clinical Supervision is regular, face-to-face contact between the designated clinical supervisor and a team member to review the client's clinical status and to ensure appropriate treatment and services are provided to the client by the team member. Clinical supervision occurs during daily organizational staff meetings and services planning meetings and includes review of written documentation (e.g., assessments, treatment plans, progress notes, correspondence).

Comprehensive Assessment is the organized process of gathering information to evaluate a client's mental and functional status and his or her treatment needs. The results of the assessment are used to develop an individual plan for services for the client.

Daily Log is a written or computer maintained notebook or cardex which the PACT team maintains on a daily basis to provide (1) a roster of clients served in the program and (2) for each program client, brief documentation of any treatment or service contacts that have occurred during the day and a concise behavioral description of the client's clinical status.

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 clients;
- (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 treatment 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 client 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 client schedules.

Individual Plan for Services is the culmination of a continuing process involving each client, his or her family, and the PACT team, which individualizes service activity and intensity to meet person-specific treatment, rehabilitation, and

support needs. The written plan documents the client's valued outcomes and the services necessary for the client to realize them. The plan also delineates the roles and responsibilities of the team members who will carry out the delivery of services.

Individual Plan for Services Review is a written summary describing client progress since the last planning meeting; it outlines client functional strengths and limitations at the time the plan is reviewed.

Individual Planning for Services Meeting is a regularly scheduled meeting, at a place and time of the client's choosing and convenient to the client and those identified by the client to be involved in the planning process conducted under the supervision of the team leader, to assess individual client needs and problems; to establish measurable long- and short- term individual goals incorporating the client's valued outcomes; to plan treatment and service interventions; and to assign staff persons responsible for providing the services.

Individual Therapy is verbal therapy in the form of one-to-one conversations with the client and focuses on helping the client understand and identify symptoms, lessen distress and symptomatology, improve role functioning, and increase participation in and satisfaction with treatment and rehabilitative services.

Individual Treatment Team is a group of three to five staff members with a range of clinical and rehabilitation skills who are assigned by the team leader within a week of the client's admission. The core members are the case manager, the psychiatrist, and one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the case manager when he or she is not working.

The individual treatment team has continuous responsibility for the following:

- (1) assessing the client's individual status and needs;
- (2) developing of the individualized plan for services with the client and the family; and
- (3) directing and providing much of the client's treatment, rehabilitation, and support services.

Individual treatment team members are assigned to take separate service roles with the client as specified in the individualized plan for services.

Initial Assessment and Individualized Plan for Services is the initial evaluation of a client's mental health status and his or her treatment and practical resource needs (e.g., housing, finances). The initial plan is completed with the client and guardian, if any, the day of admission and guides team services until the comprehensive assessment and individualized plan for services is completed.

Medication Administration is the physical act of providing medication for a client by the prescribed route.

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 Monitoring is observation of the client to determine and identify both beneficial effects and inadvertent or undesirable effects secondary to psychotropic medications.

Person-center planning is a process of learning how people want to live and to help them to achieve lives that are fulfilling to them. It is a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires and that takes place at times and locations convenient to the individual.

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 anti-anxiety agents.

Shift Manager is the individual (assigned by the team leader) in charge of developing and implementing the daily staff assignment schedule; making all daily assignments; ensuring that all daily assignments are completed or rescheduled; and managing all emergencies or crises that arise during the course of the day, in consultation with the team leader and the psychiatrist.

Weekly Client 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 client's individualized plan for services. This schedule shall be developed and maintained for each client enrolled in PACT.