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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1630 Session of 2015

INTRODUCED BY DAVIDSON, KINSEY, ROZZI, MURT, COHEN, THOMAS, YOUNGBLOOD, DEAN, DAVIS, BISHOP, V. BROWN, BULLOCK AND DRISCOLL, OCTOBER 15, 2015

REFERRED TO COMMITTEE ON HEALTH, OCTOBER 15, 2015

AN ACT

Amending the act of July 9, 1976 (P.L.817, No.143), entitled "An act relating to mental health procedures; providing for the treatment and rights of mentally disabled persons, for voluntary and involuntary examination and treatment and for determinations affecting those charged with crime or under sentence," establishing an Assertive Community Treatment Program in the Department of Human Services.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, is amended by adding articles to read:

ARTICLE III-A

(RESERVED)

ARTICLE III-B

ASSERTIVE COMMUNITY TREATMENT

Section 301-B. Declaration of policy.

The General Assembly finds and declares as follows:

(1) ACT services are targeted to individuals with serious mental illnesses that cause symptoms and impairments

in basic mental and behavioral processes.

(2) Patients are not excluded from ACT services because of severity of illness, disruptiveness in the community or hospital or failure to participate in or respond to traditional mental health services.

(3) ACT services are individually tailored for each patient through relationship building, individualized assessment and planning and active involvement with a patient to enable each patient:

(i) to find and live in his own residence;

(ii) to find and maintain work in the community;

(iii) to better manage symptoms;

(iv) to achieve individual goals; and

(v) to maintain optimism and recover.

(4) The ACT team shall advocate for patients' self-determination and independence in day-to-day activities.

Section 302-B. Definitions.

The following words and phrases when used in this article shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"ACT services." Assertive community treatment services provided in accordance with this article.

"ACT team." A group of multidisciplinary mental health staff who work as a team to deliver ACT services.

"Assertive community treatment" or "ACT." A service delivery model for providing comprehensive community-based treatment to individuals with serious mental illness that is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation and support

services that patients need to achieve their goals.

"Comprehensive assessment." The organized process of gathering and analyzing current and past information with each patient and the patient's family, support system and other significant people to evaluate:

(1) Mental and functional status.

(2) Effectiveness of past treatment.

(3) Current treatment, rehabilitation and support needs to achieve individual goals and support recovery.

"DACTS." The Dartmouth Assertive Community Treatment Scale, a research-based instrument developed to assess the degree to which an ACT provider achieves the ACT model and to quantify the requirements related to a provider's organization, structure and provision of direct services. The department shall identify the version of DACTS for use as an assessment tool.

"Department." The Department of Human Services of the Commonwealth.

"DSM." The Diagnostic and Statistical Manual of Mental Disorders or any successor.

"Homeless." When an individual lives outdoors or the primary residence of an individual during the night is in a supervised public or private facility that provides temporary living accommodations.

"Imminent risk of being homeless." A situation in which an individual meets at least one of the following criteria:

(1) Doubled-up living arrangement where the individual's name is not on the lease.

(2) Living in a condemned building without a place in which to move.

(3) Having arrears in rent and utility payments with no

ability to pay.

(4) Having received an eviction notice without a place in which to move.

(5) Living in temporary or transitional housing that carries time limits or being discharged from a health care or correctional facility without a place to live.

"Individual treatment team." A group or combination of a minimum of three to five team members who together have a range of clinical and rehabilitation skills and expertise who are assigned to a particular patient.

"Individual supportive therapy." Verbal therapies, including psychotherapy, that help individuals make changes in their feelings, thoughts and behavior in order to move toward recovery, clarify goals and address self-esteem issues. Supportive therapy helps patients identify and achieve personal goals, understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning and evaluate treatment and rehabilitative services. Psychotherapy approaches include cognitive behavioral therapy, personal therapy and psychoeducational therapy.

"Initial assessment." An initial evaluation of a patient to determine the following:

(1) The patient's mental and functional status.

(2) The effectiveness of past treatment.

(3) The current treatment, rehabilitation and support service needs.

"Mental health advance directive." A written document that describes a patient's advance directive and preference for treatment in the event that the patient's mental illness renders the patient unable to make decisions.

"Office of Mental Health and Substance Abuse Services." The Office of Mental Health and Substance Abuse Services in the Department of Human Services.

"Patient." An individual who has agreed to receive services and is receiving patient-centered treatment, rehabilitation and support services from an ACT team.

"Patient-centered community support plan." The culmination of a collaborative process involving a patient, the patient's family with the patient's consent, the patient's identified support network and the ACT team, which sets forth in writing a plan that individualizes service activity and intensity to meet patient-specific treatment, rehabilitation and support needs. The plan documents a patient's self-determined goals and the services necessary to help the patient achieve them. The plan also delineates the roles and responsibilities of team members who will carry out the services.

"Patient-centered individualized treatment plan." A patient-centered community support plan.

"Peer support." Supportive intervention provided by a certified peer specialist who has experience as a recipient of mental health services for serious mental illness. The term includes drawing on common experiences as well as using and sharing practical experiences and knowledge gained as a recipient of mental health services, which may validate patients' experiences and provide guidance and encouragement to patients to take responsibility and actively participate in their own recovery.

"Program." The Assertive Community Treatment Program established in section 303-B.

"Provider." A provider of ACT services licensed by the

department under section 304-B.

"Recovery." A self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.

"Service coordination." A process of organization and coordination within a multidisciplinary team to carry out the range of treatment, rehabilitation and support services each patient expects to receive in accordance with the patient's treatment plan.

"Team member." An ACT team member.

"Treatment plan." A patient-centered community support plan or patient-centered individualized treatment plan.

"Wellness Recovery Action Plan" or "WRAP." A tool designed for self-management of illness and wellness that is facilitated only by those who have completed department-approved training.

Section 303-B. Program.

(a) Establishment.--The department shall establish in its Office of Mental Health and Substance Abuse Services the Assertive Community Treatment Program to deliver ACT services in each county of this Commonwealth.

(b) Organization.--An ACT team shall be organized or identified as a separate service within the organization of the provider. Teams operating in urban and rural settings shall be designated as full-size teams and modified teams, respectively, as determined by the department.

Section 304-B. Eligibility.

(a) Provider participation.--ACT providers shall be licensed and approved by the department. A prospective provider shall

complete an enrollment application and list each service location that will be performing ACT.

(b) Patient eligibility.--An individual who is 18 years of age or older and has serious and persistent mental illness shall be eligible for ACT services. An individual shall be considered to have a serious and persistent mental illness when all of the following criteria are met:

(1) Primary diagnosis of schizophrenia or other psychotic disorders, such as schizoaffective disorder or bipolar disorder as defined in the DSM. Individuals with a primary diagnosis of a substance use disorder, intellectual disability or brain injury are not eligible patients.

(2) Global Assessment of Functioning Scale, as specified in DSM, ratings of 40 or below.

(3) Patients who meet at least two of the following criteria:

(i) At least two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months that may include admissions to psychiatric emergency services.

(ii) Intractable severe major symptoms.

(iii) Co-occurring mental illness and substance use disorders of more than six months' duration at the time of contact.

(iv) High-risk or recent history of criminal justice system involvement, which may include frequent contact with law enforcement personnel, incarcerations, parole or probation.

(v) Homeless, at imminent risk of being homeless or residing in unsafe housing.

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

(4) Difficulty effectively utilizing traditional case management or office-based outpatient services or evidence that a more assertive and frequent non-office-based service is required to meet clinical needs.

(c) Exception.--An individual who does not meet the requirements identified in subsection (b) may be eligible for ACT services upon written prior approval by the behavioral health managed care organization or the county mental health and intellectual disability office, as applicable. In order to meet the DACTS standard related to admission criteria, at least 90% of the patients admitted to the program shall meet the eligibility criteria under this article.

Section 305-B. Discharge.

(a) General rule.--The program shall not have an arbitrary time limit for patients to receive ACT services. An ACT team shall remain a point of contact for patients as needed. The provider shall have a no-drop-out policy and work to retain patients at a mutually satisfactory level. In order to meet DACTS standards for patient retention, at least 95% of a provider's caseload must be retained over a 12-month period. A discharge from ACT services may occur when a patient:

(1) Has successfully reached individually established goals for discharge and when the patient and program staff mutually agree to the termination of services.

(2) Has successfully demonstrated an ability to function in all major functional areas, including work, social and self-care, without ongoing assistance from the program, without significant relapse when services are withdrawn and when the patient requests termination of services. When a patient is discharged to a lower level of care, based on a careful assessment of readiness and upon mutual agreement, the process shall involve a transition period, including at least 30 days of overlap of responsibility for monitoring the patient's status and progress. The patient shall also have the option to reenroll with the provider. After the transition period has ended, the ACT team shall periodically monitor the patient's engagement with a new agency until the patient is assessed to have fully and successfully engaged with the new agency.

(3) Moves outside the geographic area of the ACT team's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to a provider or other entity within the patient's new geographic location. The ACT team shall maintain contact with the patient until the service transfer is implemented.

(b) Treatment refusal.--If an individual declines or refuses services and requests discharge despite an ACT team's attempts to engage the individual in treatment, discharge or transfer to a lower level of care shall not occur until a thorough review of the circumstances, clinical situation, risk factors and strategies to reengage the individual is conducted and documented.

Section 306-B. Responsibilities of county administrators.

County mental health administrators in partnership with

managed care organizations, as appropriate, shall be responsible for identifying the need for ACT services, providing for implementation of the program in the county and developing a fiscal plan to address program costs. County administrators shall ensure that the latest version of DACTS is completed annually for each ACT team either by the managed care organization or a consultant familiar with DACTS. The results of the most recent DACTS shall be made available to the department. The Office of Mental Health and Substance Abuse Services' field office staff shall monitor the compliance of ACT providers under their jurisdiction with the provisions of this article. The county administrators and managed care organizations shall be responsible for providing fiscal and program outcome reports as requested by the department.

Section 307-B. Responsibilities of providers.

Providers shall adhere to the requirements set forth in this article and submit reports as required by the department and the county administrator. The ACT team shall maintain written admission and discharge policies and procedures. The provider shall develop policies and procedures for each of the areas identified in the standards. Providers shall maintain the organizational and services structure that supports the program and is useful in orienting and training new staff. The following apply:

(1) Providers shall utilize a system to collect and analyze data pertaining to the program that includes data required to complete annually the latest version of the DACTS. The system shall be capable of measuring outcomes, and the data analysis results from the system shall be used to improve services and processes.

(2) Providers shall establish the minimum number of staff persons required to cover shifts, set the frequency of staff services contacts with patients and require gradual admission of patients to the ACT team.

(3) An ACT team shall systematically identify any need for assertive engagement strategies, use motivational interventions and employ therapeutic limit setting interventions only when needed.

Section 308-B. Department requirements.

(a) General rule.--

(1) The department shall establish minimum staff requirements for full-size and modified ACT teams.

(2) The department shall provide standards for use by providers in coordinating with health insurers for coverage of ACT services, including specific time frames for reevaluation of patients to determine their continuing eligibility for ACT services.

Section 309-B. Personnel duties for providers.

A provider shall:

(1) Maintain written personnel policies and procedures for hiring.

(2) Establish core staff competencies, orientation and training.

(3) Maintain personnel files for each team member containing the job application, copies of credentials or licenses, position description, annual performance appraisals and individual orientation and training plan.

Section 310-B. Patient-centered assessment and individualized treatment planning.

(a) Assessment and treatment planning.--A patient and an

individual treatment team shall work together to formulate a patient-centered individualized treatment plan. The individual treatment team members are assigned to work with a patient by the team leader and psychiatrist prior to the first treatment planning meeting or 30 days after admission, whichever occurs first. The core members are the service coordinator, psychiatrist and one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the service coordinator when the service coordinator is unavailable. The individual treatment team has the responsibility to:

(1) Be knowledgeable about the patient's life, circumstances, goals and desires.

(2) Collaborate with the patient to develop and write the treatment plan.

(3) Offer options and choices in the treatment plan.

(4) Ensure that immediate changes are made as a patient's needs change.

(5) Advocate for the patient's wishes, rights and preferences and support the patient in articulating goals and plans.

(6) Provide the majority of the patient's treatment, rehabilitation and support services. Individual treatment team members are assigned to take separate service roles with the patient as specified by the patient and the individual treatment team in the treatment plan.

(b) Initial assessment.--An initial assessment shall be completed the day of the patient's admission by the team leader or the psychiatrist, with participation by designated team members. The initial assessment 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 law enforcement, courts and outpatient and inpatient facilities, where applicable. The assessment shall include a review of all aspects of an individual's life, including physical health, and shall not be limited to mental health information only. The results of the information gathering and analysis are used to establish the initial treatment plan to support recovery and help the patient achieve individual goals. The patient's initial assessment and treatment plan guide team services until the comprehensive assessment and treatment plan are completed. At a minimum, the initial assessment shall contain the following patient information, with patient strengths listed for each appropriate item:

(1) Name and date of birth.

(2) Telephone number.

(3) Next of kin.

(4) Emergency contact.

(5) Date of admission to the program.

(6) Social Security number.

(7) Presenting problem.

(8) Self-assessment of problem.

(9) Reason for treatment.

(10) Availability of social supports and resources.

(11) History of psychiatric illness and previous services.

(12) Developmental and social history.

(13) Current functioning.

(14) Mental health diagnosis per the DSM.

(15) Primary care physician information.

(16) Physical health diagnosis.

(17) Current medication list.

(18) Justification for admission.

(19) Name of the primary case manager.

(c) Initial treatment plan.--A patient's initial treatment plan shall be completed on the day of admission and shall guide ACT team services until the comprehensive assessment and comprehensive treatment plan are completed. Interventions from the initial treatment plan shall be reported on the patient's weekly schedule. The service coordinator and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatrist at the initial treatment planning meeting. The time frame to assign the service coordinator and individual treatment team members shall not exceed six weeks from the date of admission. At a minimum, the initial treatment plan shall contain the following information:

(1) Patient name.

(2) Date.

(3) Short-term goals.

(4) Problems to be addressed.

(5) Objectives.

(6) Patient or guardian participation.

(7) Patient's signature.

(8) Team leader's signature.

(d) Comprehensive assessment.--Each part of the assessment shall be completed by a team member with skill and knowledge in the area being assessed. The assessment is based upon all available information, including information obtained from patient interview, family members of the patient and other significant parties and written summaries from other agencies,

including law enforcement, courts and outpatient and inpatient facilities, where applicable. The results of the information gathering and analysis are used to establish immediate and long-term service needs, to set goals and to develop the initial treatment plan with each patient. A comprehensive assessment shall be initiated and completed within six weeks after a patient's admission according to the following requirements:

(1) In collaboration with the patient, the individual treatment team shall complete a psychiatric and social functioning history timeline to chronologically organize information about significant events in a patient's life, the patient's experience with mental illness and treatment history. The individual treatment team shall analyze and evaluate the information systematically to formulate hypotheses for treatment and to determine appropriate treatment and rehabilitation approaches and interventions with the patient.

(2) In collaboration with the patient, the comprehensive assessment shall include an evaluation in the following areas:

(i) Psychiatric history, mental status and diagnosis. The psychiatrist shall be responsible for completing the psychiatric history, mental status and diagnosis assessment. A psychiatrist or a clinical or counseling psychologist shall make an accurate diagnosis. The psychiatrist shall present the assessment findings at the initial treatment planning meeting. The psychiatric history, mental status and diagnosis assessment shall include information from the patient, the patient's family and past treatment records regarding onset,

precipitating events, course and effect of illness, including past treatment and treatment responses, risk behaviors and current mental status. The psychiatric history, mental status and diagnosis assessment shall be used to effectively plan with the patient and the patient's family the best treatment approach in order to ensure accuracy of the diagnosis, to eliminate or reduce symptomatology and to improve social, vocational and avocational functioning.

(ii) Physical health. A registered nurse shall be responsible for completing the physical health assessment. The registered nurse shall present the assessment findings at the initial treatment planning meeting. The physical health assessment shall assess health status and any medical conditions present to ensure that appropriate treatment, follow-up and support are provided to the patient. The first interview of a patient for the purpose of assessment shall take place within 72 hours of admission.

(iii) Use of drugs or alcohol. A team member with experience and training in dual diagnosis substance abuse assessment and treatment shall be responsible for completing the use of drugs and alcohol assessment. The substance abuse specialist shall present the assessment findings at the initial treatment planning meeting.

(iv) Education and employment. A team member with experience and training in vocational assessment and services shall be responsible for completing the education and employment assessment. The vocational specialist shall present the assessment findings at the

initial treatment planning meeting. A provider shall not exclude a patient due to poor work history or ongoing symptoms or impairments related to mental illness. The education and employment assessment shall determine current school or employment status, interests and preferences regarding school and employment and how symptomatology has affected previous and current school and employment performance.

(v) Social development and functioning. A team member who is interested and skillful in attainment and restoration of social and interpersonal skills and relationships and who is knowledgeable about human development shall be responsible for completing the social development and functioning assessment. The team member who completes the assessment shall present the assessment findings at the initial treatment planning meeting. The social development and functional assessment shall obtain information from the patient about the patient's childhood, early attachments, role in family of origin, adolescent and young adult development, culture, religious beliefs, leisure activities, interests and social skills. The ACT team shall evaluate how symptomatology has interrupted or affected personal and social development, collect information regarding the patient's involvement with the criminal justice system and identify social and interpersonal issues appropriate for individual supportive therapy.

(vi) Activities of daily living (ADL) assessment. Occupational therapists and nurses shall be responsible to complete the ADL assessment. Other staff members with

appropriate training and who have interest in and compassion for patients in this area may complete the ADL assessment. The team member who completes the assessment shall present the assessment findings at the initial treatment planning meeting. The ADL assessment shall enable the ACT team to determine the level of assistance, support and resources the patient needs to reestablish and maintain ADL. The ADL assessment shall evaluate:

(A) The individual's current ability to meet basic needs.

(B) The quality and safety of the patient's current living situation.

(C) The adequacy of the patient's financial resources.

(D) The effect that symptoms and impairments of mental illness have had on self-care.

(E) The patient's ability to maintain an independent living situation.

(F) The patient's desires and individual preferences.

(vii) Family structure and relationships. Members of a patient's individual treatment team shall be responsible for carrying out the family structure and relationships assessment. The staff members working with the family shall present the assessment findings at the initial treatment planning meeting. The purpose of the family structure and relationships assessment shall be to obtain information from the patient's family and other significant people about their perspective of the patient's mental illness and to determine their level of

understanding about mental illness as well as their expectations of ACT services. This information shall allow the ACT team to define the contact or relationship between the patient and the patient's family in regard to the patient's goals, treatment and rehabilitation. The assessment shall begin at the time of admission.

(3) A patient's psychiatrist, service coordinator and individual treatment team members shall assume responsibility for preparing the written narrative of the results and formulation of the psychiatric and social functioning history timeline and the comprehensive assessment. The psychiatric and social functioning history timeline and comprehensive assessment shall be completed within six weeks of the patient's admission to the program.

(e) Individualized community support planning.--The ACT team shall use recovery planning tools, such as WRAP, and shall incorporate the individual's recovery planning into all aspects of treatment and service planning. The ACT team shall also develop mental health advance directives with each patient, unless the patient declines. Treatment plans shall be developed within eight weeks of admission through the following treatment planning process:

(1) A treatment plan shall be developed in collaboration with the patient and the patient's family or guardian, if any, when feasible and appropriate. The patient's participation in the development of the treatment plan shall be documented. The ACT team and the patient shall assess the patient's needs, strengths and preferences and develop a treatment plan. The treatment plan shall be guided primarily by the patient's self-selected goals and it shall:

(i) Identify individual strengths, issues and problems.

(ii) Set specific measurable short-term and long-term goals for each issue and problem.

(iii) Establish the specific approaches and interventions necessary for the patient to meet the stated goals, improve capacity to function as independently as possible in the community and achieve the maximum level of recovery possible.

(2) Team members shall meet at regularly scheduled times for treatment planning meetings. At each meeting, the following staff shall attend:

(i) Team leader.

(ii) Psychiatrist.

(iii) Service coordinator.

(iv) Individual treatment team members.

(v) Peer specialist.

(vi) Other team members involved in regular tasks with the patient.

(3) Individual treatment team members shall be responsible to ensure the patient is actively involved in the development of recovery and service goals. With the permission of the patient, team members shall also involve pertinent agencies and members of the patient's social network in the formulation of treatment plans.

(4) Each patient's treatment plan shall identify the patient's issues and problems, strengths and weaknesses and specific measurable short-term and long-term recovery goals. The plan shall clearly specify the approaches and interventions necessary for the patient to achieve the

individual goals and identify who will carry out the approaches and interventions. A treatment plan shall incorporate two or more strengths and resources as identified in the comprehensive assessment.

(5) The following key areas should be addressed in each patient's treatment plan:

(i) Psychiatric illness or symptom reduction.

(ii) Housing.

(iii) Activities of daily living.

(iv) Daily structure and employment.

(v) Family and social relationships.

(vi) Trauma assessment.

(vii) Violence assessment.

(6) The service coordinator and the individual treatment team, together with the patient, shall be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the patient's course of treatment or at least every six months, whichever comes first. The service coordinator shall prepare a summary which thoroughly describes in writing the patient's and the individual treatment team's evaluation of patient progress and goal attainment, the effectiveness of the interventions and the patient's satisfaction with services since the most recent treatment plan. The plan and review shall be signed or verbally approved by the patient, service coordinator, individual treatment team members, team leader, psychiatrist and team members.

(7) An ACT team shall maintain written assessment and treatment planning policies and procedures incorporating the requirements outlined in this section.

Section 311-B. Required services.

(a) General rule.--An ACT team shall provide comprehensive treatment, rehabilitation and support services as a self-contained service unit. Services shall at a minimum include the following:

(1) Service coordination. Each patient shall be assigned a service coordinator who shall have the primary responsibility for a patient. A service coordinator shall lead and monitor the activities of the patient's individual treatment team and is responsible for service coordination for the patient. Service coordination shall include coordination with community resources, including patient self-help and advocacy organizations that promote recovery. Members of the patient's individual treatment team shall share service coordination duties with the service coordinator and are responsible for performing the duties in the absence of the service coordinator. In all cases, team members work with each patient and shall be conversant with a patient's strengths, background and treatment plan. A service coordinator:

(i) Has primary responsibility for:

(A) Establishing and maintaining a therapeutic relationship with the patient on a continuing basis.

(B) Collaborating with the patient to develop a treatment plan.

(C) Providing individual supportive therapy.

(D) Offering options and choices in the treatment plan.

(E) Ensuring that immediate changes are made as the patient's needs change.

(F) Advocating for the patient's wishes, rights and preferences.

(ii) May be the first staff person called upon when the patient is in crisis.

(iii) Provides primary support and education to the patient's family and support system and to other significant people in the patient's life.

(iv) Works with community resources, including the county mental health and intellectual disability office and patient-run services, to coordinate and integrate these resources into the patient's treatment plan.

(2) Crisis assessment and intervention. Crisis assessment and intervention that includes telephone and face-to-face contact shall be provided 24 hours a day, seven days a week.

(3) Symptom assessment and management, including, but not limited to, the following:

(i) Ongoing comprehensive assessment of the patient's mental illness symptoms, accurate diagnosis and the patient's response to treatment.

(ii) Psychoeducation regarding mental illness and the effects and side effects of prescribed medications.

(iii) Symptom management efforts directed to help each patient identify and target the symptoms and occurrence patterns of mental illness and develop methods to help lessen the effects.

(iv) Individual supportive therapy.

(v) Psychotherapy.

(vi) Psychological support, on a planned and as-needed basis, to help patients accomplish their personal

goals, to cope with the stressors of day-to-day living and to recover.

(4) Medication prescription, administration, monitoring and documentation by psychiatrist. The ACT team psychiatrist shall:

(i) Establish an individual clinical relationship with each patient.

(ii) Assess each patient's mental illness symptoms and determine how these symptoms affect the patient's ability to function productively and provide verbal and written information about mental illness to the ACT team, the patient and the patient's family or significant others with the patient's consent.

(iii) Make an accurate diagnosis based on the comprehensive assessment.

(iv) Provide education about medication, benefits and risks and obtain informed consent.

(v) Assess and document the patient's mental illness symptoms, behavior and social and community involvement in response to medication and monitor and document medication side effects.

(vi) Provide psychotherapy.

(5) Medication prescription, administration, monitoring and documentation by team members. Team members shall assess and document a patient's mental illness symptoms and behavior in response to medication and shall monitor medication side effects.

(6) Medication prescription, administration, monitoring and documentation by program. The program shall establish medication policies and procedures consistent with applicable

Federal and State law to identify processes to:

(i) Record physician orders.

(ii) Order medication.

(iii) Arrange for patient medications to be organized by the ACT team and integrated into patients' weekly schedules and daily staff assignment schedules.

(iv) Provide security for medications and set aside a private designated area for set up of medications by the ACT team's nursing staff.

(v) Administer medications in accordance with State law.

(7) Dual diagnosis substance abuse services as follows:

(i) Provision of a stage-based treatment model that:

(A) is nonconfrontational;

(B) considers interactions of mental illness and substance abuse;

(C) follows cognitive-behavioral principles;

(D) does not expect complete abstinence and supports harm reduction;

(E) understands and applies stages of change readiness in treatment;

(F) incorporates skillful use of motivational interviewing interventions; and

(G) has patient-determined goals.

(ii) A stage-based treatment model shall include, but is not limited to, individual and group interventions in:

(A) Engagement.

(B) Assessment, such as stage of readiness to change and patient-determined problem identification.

(C) Motivational enhancement, such as developing discrepancies and psycho-education.

(D) Active treatment, such as cognitive skills training and community reinforcement.

(E) Continuous relapse prevention, such as trigger identification and building relapse prevention action plans.

(8) Work-related services. Work-related services are those services that help patients value, find and maintain meaningful employment in community-based job sites. Work-related services include, but are not limited to:

(i) 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.

(ii) Assessment of the effect of the patient's mental illness on employment with identification of specific behaviors that interfere with the patient's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

(iii) Development of an ongoing employment rehabilitation plan to help each patient establish the skills necessary to find and maintain a job.

(iv) Individual supportive therapy to assist patients to identify and cope with mental illness symptoms that may interfere with their work performance.

(v) On-the-job or work-related crisis intervention.

(vi) Work-related supportive services, such as assistance with grooming and personal hygiene, securing

of appropriate clothing, wake-up calls and transportation, if needed.

(vii) Maintaining ongoing relationships with employers to facilitate the creation of work environments that would be conducive to the hiring of patients seeking employment.

(viii) Assisting patients in locating jobs that they are interested in and making the initial contact with the employer to arrange for any accommodations as necessary or if requested by patients.

(9) Activities of daily living. Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient assistance and support, skill training, ongoing supervision and environmental adaptations to assist patients to gain or use the skills required to:

(i) Find housing which is safe, of good quality and affordable, and make living arrangements.

(ii) Perform household activities, including house cleaning, cooking, grocery shopping and laundry, and carry out personal hygiene and grooming tasks, as needed.

(iii) Develop or improve money management skills.

(iv) Use available transportation.

(v) Have and effectively use a personal physician and dentist.

(10) Social and interpersonal relationship and leisure time skill training. Services to support social and interpersonal relationships and leisure time skill training include individual supportive therapy; social skills teaching and assertiveness training; planning, structuring, and

prompting of social and leisure time activities; support and coaching; and organizing individual and group social and recreational activities to structure patients' time, increase their social experiences and provide them with opportunities to practice social skills and receive feedback and support required to:

(i) Improve communication skills, develop assertiveness and increase self-esteem.

(ii) Develop social skills, increase social experiences and develop meaningful personal relationships.

(iii) Plan appropriate and productive use of leisure time.

(iv) Relate to landlords, neighbors and others effectively.

(v) Become familiar with available social and recreational opportunities and increase use of such opportunities.

(11) Peer support services. Peer support services validate patients' experiences and guide and encourage patients to take responsibility for and actively participate in recovery. In addition, these services help patients identify, understand and combat stigma and discrimination against mental illness and develop strategies to enhance self-esteem. Peer support services are multifaceted and include, but are not limited to:

(i) Individual advocacy, crisis management support and skills training.

(ii) Introduction and referral to patient self-help programs and advocacy organizations that promote

recovery.

(iii) Access and utilization of natural resources within the community.

(iv) Cultivation of self-worth and a sense of wellness.

(v) Modeling recovery-oriented attitudes and behaviors.

(12) Support services. Support services or direct assistance to ensure that patients obtain the basic necessities of daily life, including, but not limited to:

(i) Medical and dental services.

(ii) Safe, clean, affordable housing. An ACT team shall partner with patients in individual housing assessment and planning. Patients may choose housing in the most integrated setting possible.

(iii) Financial support and benefits counseling.

(iv) Social service.

(v) Transportation.

(vi) Legal advocacy and representation.

(13) Education and support of and consultation with patients' families and other support services. Services provided regularly under this category to patients' families and other support services, with patient agreement or consent, shall include:

(i) Individualized psychoeducation about the patient's illness and the role of the family and other significant people in the therapeutic process.

(ii) Intervention to restore contact, resolve conflict and maintain relationships with family and other significant people.

(iii) Ongoing communication and collaboration, face-to-face and by telephone, at least two times per month for each patient, between the ACT team and the patient's family and other significant people.

(iv) Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

(v) Assistance to patients with children, including individual supportive therapy, parenting training and service coordination, including, but not limited to:

(A) Services to help patients throughout pregnancy and the birth of a child.

(B) Services to help patients fulfill parenting responsibilities and coordinate services for their children.

(vi) Services to help patients restore relationships with children who are not in the patient's custody.

(b) Duties of provider.--The provider shall maintain written policies and procedures for all services outlined in this section. If a patient requires services that an ACT team is not mandated to provide, the team shall coordinate those services with other providers or entities or consult with other providers or entities to assist the team in meeting the comprehensive needs of the individual.

Section 312-B. Recordkeeping.

Records shall be maintained in accordance with department guidelines to verify compliance with the requirements of this article and shall be retained for a minimum of seven years. Site survey reports, employee schedules, payroll records, patient case records, medication records, job descriptions, documents

verifying employee qualifications and training, policies and protocols, fees or charges, records of supervision and training, letters of agreements with referral sources and service agencies and a grievance and appeals process are records that shall be kept to verify compliance with this article.

Section 313-B. Patient rights and grievance procedures.

(a) General rule.--Providers shall have and maintain policies and procedures for patient rights and grievance procedures that ensure compliance with Federal and State laws and ensure that all team members fully understand, inform and respect a patient's right to appropriate treatment in a setting and under conditions that are the most supportive of each individual's personal liberty and restrict such liberty only to the extent necessary consistent with each patient's treatment needs, applicable requirements of law and applicable judicial orders.

(b) Confidentiality and treatment conditions.--Providers shall be knowledgeable about and familiar with patient rights, including the right to:

(1) Confidentiality.

(2) Informed consent to medication and treatment.

(3) Treatment with respect and dignity.

(4) Prompt, adequate and appropriate treatment.

(5) Treatment which is under the least restrictive conditions.

(6) Nondiscrimination.

(7) Control own money.

(8) File grievances or complaints.

(9) Mental health advance directives.

(c) Grievance and complaint procedures.--Providers shall be

knowledgeable about and familiar with the mechanisms to implement and enforce patient rights with regard to:

(1) Grievance or complaint procedures under State law.

(2) Medicaid.

(3) The Americans with Disabilities Act of 1990 (Public Law 101-336, 104 Stat. 327).

(4) Protection and advocacy for individuals with mental illness.

(5) Mental health advance directives.

Section 314-B. Culturally and linguistically appropriate services.

Providers shall:

(1) Ensure that patients receive effective, understandable and respectful care that is provided in a manner compatible with patients' cultural health beliefs and practices and written and spoken language preferences, including American Sign Language and Braille.

(2) Maintain written culturally and linguistically appropriate services policies and procedures in accordance with this section.

(3) Implement strategies to recruit, retain and promote a diverse staff that are representative of the demographic characteristics of the service area.

(4) Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

(5) Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during hours of

operation.

(6) Provide to patients, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.

(7) Assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff. Family and friends shall not be used to provide interpretation services except when requested by the patient.

(8) Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and groups represented in the service area.

(9) Develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services.

(10) Conduct initial and ongoing organizational self-assessments of culturally and linguistically appropriate services and related activities and are encouraged to integrate cultural and linguistic competence-related measures into providers' internal audits, performance improvement programs, patient satisfaction assessments and outcome-based evaluations.

(11) Ensure that data on the individual patient's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.

(12) Develop participatory and collaborative partnerships with communities and utilize a variety of formal

and informal mechanisms to facilitate community and patient involvement in designing and implementing culturally and linguistically appropriate services and related activities.

(13) Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients.

(14) Make available to the public information about implementing the culturally and linguistically appropriate services standards and provide public notice in the community served of the availability of this information.

Section 315-B. Performance improvement and program evaluation.

(a) General rule.--Providers shall maintain performance improvement and program evaluation policies and procedures. Each provider shall evaluate the following:

(1) Patient outcome.

(2) Patient and family satisfaction with the services, including independent patient family satisfaction team reviews.

(3) The degree to which a provider conforms to the ACT model using the latest version of DACTS. The DACTS shall be completed annually for each provider either by the managed care organization or a consultant familiar with DACTS. DACTS scores shall be used to determine any corrective actions. The department shall review the results of the DACTS scale along with the program standards as part of the licensing and approval process.

(b) Plan.--A provider shall have a performance improvement and program evaluation plan, which shall include the following:

(1) A statement of the objectives relating directly to

the program's patients or target population.

(2) Measurable criteria that shall be applied in determining whether or not the stated 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.

(c) System.--A provider shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices and other factors that may contribute to the effective use of the program's resources.

Section 316-B. Rate setting and payment.

The department shall issue separate communications to address rate setting and payments.

Section 317-B. ACT advisory committee.

(a) Policies and procedures.--A provider shall maintain written advisory committee policies and procedures, incorporating the requirements outlined in this section.

(b) Advisory committee.--Each provider shall establish an advisory committee to support and enhance the ACT team through assistance with start up, implementation and ongoing operations. The committees shall support ACT teams as the providers deliver each patient high quality, recovery-oriented services.

(c) Membership.--The committee membership shall be representative of the populations served by the provider and shall include representation from various stakeholder groups in the community. At least 51% of the advisory committee shall be comprised of recipients or former recipients of mental health

services and family members. Other community stakeholders and representatives from diverse community services, such as patient support organizations, food pantries, homeless shelters, housing authorities, landlords, educational institutions, the criminal justice system, employers and the business community shall constitute the remainder of the advisory committee. The committee membership shall also represent the cultural diversity of the local population.

(d) Meetings.--An advisory committee shall meet at least quarterly, with regular attendance by a team leader or designee, and shall:

(1) Promote the development and continuation of quality ACT services.

(2) Review compliance with program audits and ACT program standards.

(3) Inform and support the department's ongoing quality improvement process.

(4) Promote and ensure the presence of patients' empowerment and recovery values.

(5) Examine program outcome measures, including patient and family satisfaction.

Section 318-B. Waiver of provisions.

(a) General rule.--Providers may request waivers of requirements in program standards.

(b) Waiver conditions.--A provider may request from the department a waiver of any required standard that would not diminish the effectiveness of ACT services, violate the purposes of the program or adversely affect patients' health and welfare. A waiver shall not be granted if inconsistent with patient rights or Federal, State or local law or regulation.

(c) Admission decisions.--Requests for admission of individuals who do not meet the eligibility criteria for ACT services shall be directed to the behavioral health managed care organization or the county mental health and intellectual disability office, as applicable, for approval.

Section 2. This act shall take effect in 180 days.