

PROVIDER CERTIFICATION MANUAL
FOR
COMMUNITY SUPPORT SERVICES PROGRAMS
Community Continuum of Care Program
Residential Rehabilitation Facility
Psychosocial Rehabilitation Center

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

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OVERVIEW

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

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

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

1 CERTIFICATION FOR PROVIDER PARTICIPATION

- 1.1 Authority - Through an Inter-Divisional Agreement, the Division of Social Services (DSS) Delaware Medical Assistance Program (DMAP) has delegated the function of certifying organizations for enrollment as providers of optional behavioral health community support services to the Division of Substance Abuse and Mental Health (Division or DSAMH).**
- 1.2 Certification Criteria - Eligibility for certification to provide community support services is determined according to the following criteria:**
 - 1.2.1 Organizations eligible to apply for provider certification and enrollment with DSS for Medicaid reimbursement of Community Support Services include:**
 - 1.2.1.1 Private non-profit human service corporations;**
 - 1.2.1.2 Private for-profit human service corporations;**
 - 1.2.1.3 State, county or municipal government-operated health and human services departments.**
 - 1.2.2 The Division bases its certification of programs and enrollment recommendation to DSS upon the organization's compliance with state level organizational, administrative and program standards and with federal requirements for the administration of Medicaid services as contained in federal statutes, regulations and guidelines.**
 - 1.2.2.1 The Division may establish and apply minimum compliance guidelines to be used in making certification determinations.**
 - 1.2.3 The Division uses a certification survey to measure compliance with organizational, administrative and program standards. The determination with regard to a program's certification is based on:**
 - 1.2.3.1 Statements of the organization's authorized representatives;**
 - 1.2.3.2 Documents provided to the Division by the organization;**

1.2.3.3 Documented compliance with organizational, program and administrative standards;

1.2.3.4 On-site observations by surveyors.

1.3 Provider Certification

1.3.1 Procedures for Certification, Recertification, Suspension, Revocation and Reinstatement of Certification may be found in the Medicaid Provider-specific Policy Manual for Community Support Services (Behavioral Health Rehabilitative Services) available on the DMAP web site at <http://www.dmap.state.de.us> or from EDS provider services (telephone 302-454-7154 or 800-999-3371).

2 CLINICAL STAFF AUTHORIZED TO PROVIDE SERVICES

The provider may file claims for only those billable Community Support Services rendered by members of its clinical staff who hold the credentials required by each covered billable activity.

2.1 The categories of clinical staff and their definitions for Community Support Services Programs for persons with psychiatric disabilities are as follows:

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

2.1.2 Clinician: a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university, (or a registered nurse with a certificate in mental health nursing from the American Nurses Association).

2.1.2.1 The Clinical Supervisor must meet the minimum criteria for Clinician.

2.1.3 Associate Clinician: a person with a bachelor's degree in a human service field or a registered nurse.

2.1.3.1 Case Managers must meet the minimum criteria for Associate Clinician.

2.1.4 Assistant Clinician: a person with an associate's degree in a

human service field or a certified counselor who holds a certification from a nationally recognized certification body but lacks the academic credentials of an associate clinician.

2.1.5 Rehabilitative Services Assistant: a person with a high school diploma or GED who has received documented training that shall, at a minimum, include: 1) a complete course in medications used in the treatment of mental illness including the side effects assigned; 2) a course in mental illness including symptoms of the major mental illnesses, mood and personality disorders; 3) a course in first aid including CPR training.

3 RECIPIENT ELIGIBILITY

Eligible recipients are certified by the program physician as being in medical need of program services in accordance with an assessment procedure approved by the Division for use in determining that persons are severely disabled according to criteria for severity of disability associated with mental illness.

- 3.1** The Division may require a full review of medical necessity in the event that a determination of medical necessity by the program physician does not appear to DSAMH to be supported by the assessment materials.
- 3.2** Determination of consumer eligibility for Medicaid benefits is the sole responsibility of DSS.

4 COVERED SERVICES

Covered Services are provided only within the context of an appropriately certified Community Support Services program. Community Support Services may be billed to the Delaware Medical Assistance Program for eligible Medicaid recipients for the following activities. [Definitions for all covered services may be found in the Medicaid Provider-specific Policy Manual for Community Support Services (Behavioral Health Rehabilitative Services) available on the DMAP web site at <http://www.dmap.state.de.us> or from EDS provider services (telephone 302-454-7154 or 800-999-3371).]

4.1 Comprehensive Medical/Psychosocial Evaluation

4.2 Physician Services

4.3 Emergency Services

4.3.1. Emergency services are provided by a physician, clinician,

associate clinician, assistant clinician or rehabilitative services assistant.

4.4 Counseling and Psychotherapy Services

4.4.1. Counseling is provided by physicians, clinicians, associate clinicians and assistant clinicians who are credentialed counselors or learning and practicing under direct supervision by a credentialed clinician.

4.5 Psychiatric Rehabilitative Services

4.5.1. Psychiatric rehabilitative services are provided by a physician, clinician, associate clinician, assistant clinician or rehabilitative services assistant.

4.6 Psychosocial Rehabilitation Center Services [Services limited to provision by a Certified Psychosocial Rehabilitation Center.]

4.6.1. Services are provided by a physician, clinician, associate clinician, assistant clinician or rehabilitative services assistant.

4.7 Residential Rehabilitation Facility Services [Services limited to provision by a Certified Residential Rehabilitation Facility.]

4.7.1. Services are provided by a physician, clinician, associate clinician, assistant clinician or rehabilitative services assistant.

5 SERVICE LIMITATIONS

5.1 Limitations on optional Behavioral Health Community Support Services may be found in the Medicaid Provider-specific Policy Manual for Community Support Services (Behavioral Health Rehabilitative Services) available on the DMAP web site at <http://www.dmap.state.de.us> or from EDS provider services (telephone 302-454-7154 or 800-999-3371).

6 COMMUNITY CONTINUUM OF CARE (CCCP) STANDARDS

6.1 Program Organization and Operation

6.1.1 A CCCP shall adhere to the following hours of operation:

6.1.1.1 Highest Intensity Level: Seven days per week, a minimum of 12 hours on weekdays and 8 hours on

weekends and holidays.

6.1.1.2 Intermediate Intensity Level and Lower Intensity Level: No less than five (5) days a week, at least eight (8) hours per day. The schedule shall include at least eight hours per week outside the hours of 9:00 A.M. to 5:00 P.M.

6.1.2 A clinician, associate clinician or assistant clinician shall be on-call and available to respond face-to-face immediately during non-operating hours. A second staff member shall be on back-up on-call.

6.1.3 A CCCP program shall be organized to provide a maximum clinical staff to consumer ratio of:

6.1.3.1 1:12 with no individual staff member having a caseload of more than 20 for High Intensity Level consumer.

6.1.3.2 1:20 with no individual staff member having a caseload of more than 30 for Intermediate Intensity Level consumers.

6.1.3.3 1:30 with no individual staff member having a caseload of more than 40 for Lower Intensity Level consumers.

6.1.3.4 AT LEAST 75% OF THE CLINICAL STAFF SHALL BE FULL-TIME.

6.1.4 Each consumer shall have a treatment team consisting of at least the staff members designated as the physician, registered nurse, clinician, and case manager who are primarily involved in his/her treatment plan.

6.1.5 CCCP programs serving more than 100 consumers may break into smaller teams.

6.1.6 Each consumer's team shall meet jointly:

6.1.6.1 Each day for High Intensity Level consumers to review the contacts with and status of each consumer during the previous day and to plan contacts for the current day.

6.1.6.2 Weekly for Intermediate Intensity Level and Lower Intensity Level consumers to review the contacts with and the status of each consumer during the previous week and to plan contacts for the

following week.

- 6.1.7 The physician, clinical supervisor, case manager, at least one other member of the consumer's primary treatment team from the CCCP shall meet jointly at least weekly to conduct treatment planning and treatment plan reviews.
- 6.1.8 Program staff shall maintain regular, contact with consumers who are hospitalized for stabilization of psychiatric symptoms. Consumer contacts shall occur at least one time per hospitalization episode OR one time per week for hospital stays longer than 7 days. Program staff shall collaborate with treatment teams providing care to hospitalized consumers.

6.2 Program Staff

- 6.2.1 There shall be an overall director of the CCCP who shall be a clinician with at least three years of clinical/administrative experience in providing community support services to adults with psychiatric disabilities.
- 6.2.2 Each CCCP shall have an overall clinical supervisor who shall supervise the provision of services to consumers and the quality assurance program. The clinical supervisor shall be a clinician with at least three years of post-graduate experience in providing community support services to adults with psychiatric disabilities.
- 6.2.3 Associate clinicians and assistant clinicians shall have credentials/training for the treatment activities they engage in and shall be supervised by clinicians.
- 6.2.4 Rehabilitative Services Assistants shall conduct activities only under the direction and supervision of a clinician in the implementation of specified treatment plan objectives.
 - 6.2.4.1 Rehabilitative Services Assistants shall have documented training and/or demonstrated competence in the conduct of assigned activities.
- 6.2.5 Rehabilitative Services Assistants shall provide services only when other clinical staffs are on duty in the CCCP. Rehabilitative Services Assistants shall not at any time be the only staff persons on duty in the CCCP.
- 6.2.6 The CCCP shall have among its staff individuals who are trained, skilled and experienced to conduct the following

clinical activities: psycho-educational therapy; cognitive therapy; behavior therapy; symptom education and self-management; addictions therapy; vocational assessment and therapy; social skills training; daily living skills training; structured interviewing for completing rating scales, diagnostic interviews, mental status examinations, social security disability reports, etc.

6.2.7 All clinical staff shall be trained and supervised to provide supportive counseling and case management.

6.2.8 When volunteers or student interns are used, they shall be supervised by a clinician.

6.2.6.1 The CCCP shall have written procedures for the selection, orientation, in-service training and supervision of volunteers and students.

6.2.9 A CCCP program shall have a full or part-time physician who is available to provide direct service at CCCP sites.

6.2.9.1 The physician shall have backup arrangements with other physicians for coverage when he/she is unavailable and shall provide them with an up-to-date listing of the medications and recommendations for each consumer in the event of a crisis.

6.2.10 For every 70 consumers, there shall be at least 1.0 Full Time Equivalent (FTE) Registered Nurse(s).

6.3 Target Population

Enrollment in a CCCP shall be limited to consumers who are certified by the program physician as being in medical need of the services provided in accordance with the Division's approved assessment procedure and meet the criteria for enrollment as community support consumers.

6.4 Determination of Severity of Disability

6.4.1 The Division uses the following criteria to make a determination of severity of disability;

6.4.1.1 An established history of rapid deterioration following previous interventions for psychiatric stabilization;

6.4.1.2 The rating on Axis I through Axis V of the DSM IV TR Multiaxial System;

6.4.1.3 The degree of clinical risk evidenced by:

6.4.1.3.1 severity and interference of refractory symptoms;

6.4.1.3.2 psychosocial dysfunction;

6.4.1.3.3 impaired judgment;

6.4.1.3.4 suicidal behavior;

6.4.1.3.5 disruptive behavior.

6.5 Consumer Rights

6.5.1 The provider shall establish a formal process for soliciting consumer complaints and for reviewing treatment decisions by staff with which consumers disagree.

6.5.1.1 The provider must identify a specific staff person responsible for unbiased assistance to consumers in following and understanding the complaints and grievance process and in appropriately presenting their complaint or grievance.

6.5.2 The provider shall not establish any general conditions of program participation that limits a consumer's rights to self-determination.

6.5.3 The provider shall comply with DHSS Policy Memorandum 46 or (if not operating under contract to, or direct supervision of, DHSS) a similarly comprehensive written policy/procedure regarding the reporting of and responding to allegations of abuse and neglect, and to incidents resulting in injury or death.

6.5.4 Consumers shall be kept informed of their rights and responsibilities contained in written policies and procedures including reference to:

6.5.4.1 Behavioral expectations and limitations;

6.5.4.2 Consumer grievances;

6.5.4.3 Confidentiality including:

6.5.4.3.1 The Health Insurance Portability and Accountability Act (HIPAA), regulations 45 C.F.R. Parts 160 & 164;

AND

6.5.4.3.2 For substance abusing consumers, drug and alcohol confidentiality regulations 42 C.F.R. Part 2.

6.5.4.4 Charges for which consumers or a third party may be billed;

6.5.4.5 The process for appeal and review of problems which consumers experience in regard to the quality and responsiveness of services provided by program staff.

6.6 Intake

6.6.1 During the intake process, there shall be documentation that the consumer has been informed of:

6.6.1.1 His/her rights as defined in 6.5;

6.6.1.2 The program's services and aims;

6.6.1.3 The manner in which the program operates to ensure that consumers receive the services they need;

6.6.1.4 How consumers can obtain assistance during an emergency or whenever the program offices are closed;

6.7 Assessment

6.7.1 A Comprehensive Medical/Psychosocial Evaluation approved by the Division as a CCCP assessment procedure shall be started at the time of the consumer's admission to the Community Support Services Programs and shall be completed:

6.7.1.1 Within 30 days of admission;

6.7.1.2 When consumers move from one level to another;

AND

6.7.1.3 Annually for each consumer.

6.7.2 A clinician shall conduct the evaluation.

6.7.2.1 The evaluation shall include a written summary of the assessment. The summary shall include:

6.7.2.1.1 current psychiatric symptomatology and mental status to include multi-axial Diagnostic Statistical Manual (DSM) diagnosis according to the most recent DSM;

6.7.2.1.2 extent and effects of drug and/or alcohol use;

6.7.2.1.3 medical, dental, and optometric needs;

6.7.2.1.4 compliance with and response to prescribed medical/psychiatric treatment;

6.7.2.1.5 recent key life events;

6.7.2.1.6 vocational and educational functioning;

6.7.2.1.7 family history and social supports;

6.7.2.1.8 current social functioning;

6.7.2.1.9 legal history to include current legal issues;

6.7.2.1.10 financial status;

6.7.2.1.11 conditions of daily living, including housing;

6.7.2.1.12 recommendations for treatment to include issues to be addressed, referred and deferred.

6.7.2.2 The Comprehensive Medical/Psychosocial Evaluation shall be signed, and dated by:

6.7.2.2.2 the clinician completing the evaluation;

- 6.7.2.2.3 the physician
- AND
- 6.7.2.2.4 the clinical supervisor.

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

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

6.7.3.2 The current physical examination shall be reviewed, signed, and dated by the physician or other qualified medical personnel whose license allows them conduct and/or review physical examinations without oversight from a physician.

6.8 Determination of Consumer Service Intensity Level

6.8.1 The CCCP shall utilize assessment information to determine the level of service intensity required to substantially address the treatment/rehabilitation needs of each consumer.

6.8.1.1 The level of service intensity required by each consumer shall be determined in a uniform manner for all consumers and shall substantiate the placement of the consumer into a program component conforming to one of the Levels specified in Section 6.1.

6.8.1.2 The CCCP shall determine level of service intensity using a clearly delineated process that is sufficiently documented and structured to allow review and understanding of the process by a clinician not experienced in its use.

6.9 Treatment Planning

6.9.1 An initial written treatment plan shall be developed on the day of admission.

6.9.1.1 The initial treatment plan shall include:

6.9.1.1.1 Short-range goals, stated in measurable terms;

6.9.1.1.2 Long-range goals, stated in measurable terms;

6.9.1.1.3 Specific staff interventions planned to achieve treatment goals;

6.9.1.1.4 Frequency of interventions;

6.9.1.1.5 Areas identified in §6.7.2.1.12.

6.9.1.2 The initial treatment plan shall be reviewed, signed, and dated by:

6.9.1.2.1 The case manager;

6.9.1.2.2 The physician;

**6.9.1.2.3 The clinical supervisor;
AND**

6.9.1.2.4 The consumer

6.9.2 Within 45 days of admission, following the completion of intake assessments, the consumer's primary case manager shall develop a comprehensive written treatment plan.

6.9.2.1 The comprehensive treatment plan shall include:

6.9.2.1.1 Short-range goals, stated in measurable terms;

6.9.2.1.2 Long-range goals, stated in measurable terms;

6.9.2.1.3 Specific staff interventions planned to achieve treatment goals;

6.9.2.1.4 Frequency of interventions;

6.9.2.1.5 Other goals carried over from the treatment plan developed in §6.9.1.1.5

6.9.2.2 The consumer's participation in the development of treatment goals shall be documented.

6.9.2.3 The comprehensive treatment plan shall be reviewed, signed, and dated by:

6.9.2.3.1 The case manager;

6.9.2.3.2 The physician;

**6.9.2.3.3 The clinical supervisor;
AND**

6.9.2.3.4 The consumer.

6.9.3 The treatment plan shall be reviewed in full at least every six months at a treatment planning and review meeting. As a result of the review a new treatment plan shall be written.

6.9.3.1 The treatment plan update shall include:

6.9.3.1.1 Short-range goals, stated in measurable terms;

6.9.3.1.2 Long-range goals, stated in measurable terms;

6.9.3.1.3 Specific staff interventions planned to achieve treatment goals;

6.9.3.1.4 Frequency of interventions including:

6.9.3.1.4.1 Goals that have been met

6.9.3.1.4.2 Goals that have not been met

6.9.3.1.4.3 New goals for the current treatment plan

6.9.3.1.4.4 Whether or not goals are being treated, referred or deferred.

6.9.3.2 The consumer's participation in the development of treatment goals shall be documented.

6.9.3.3 The treatment plan update shall be signed and dated by:

6.9.3.3.1 The case manager;

6.9.3.3.2 The physician;

- 6.9.3.3.3 The clinical supervisor
- AND
- 6.9.3.3.4 The consumer.

6.9.4 Each time a consumer moves from a lower level of care to a higher level of care, or from a higher level of care to a lower level of care, a treatment plan update shall be completed in accordance with 6.9.3 of these standards.

6.10 Crisis Intervention Plan

6.10.1 The Crisis Intervention Plan shall include Advance Directives that include:

- 6.10.1.1 Consumer-driven recommended procedures for crisis or emergency resolution;
- 6.10.1.2 Specific persons and/or programs to contact in times of crisis;
- 6.10.1.3 Signs and symptoms of decompensation or relapse for the consumer;
- 6.10.1.4 Methods for preventing crisis;
- 6.10.1.5 Directives to be used in medical crisis situation;

6.10.2 An initial written crisis intervention plan shall be developed on the date of admission.

6.10.2.1 The initial crisis intervention plan shall be reviewed, signed, and dated by:

- 6.10.2.1.1 The case manager;
- 6.10.2.1.2 The physician;
- 6.10.2.1.3 The clinical supervisor
- AND
- 6.10.2.1.4 The consumer.

6.10.3 Within 45 days of admission, a comprehensive written crisis intervention plan shall be developed.

6.10.3.1 The comprehensive crisis intervention plan shall be reviewed, signed, and dated by:

6.9...1 The case manager;

6.10.3.1.2 The physician,

**6.10.3.1.3 The clinical supervisor;
AND**

6.10.3.1.3 The consumer.

6.10.4 The comprehensive written crisis intervention plan shall be reviewed in full at least every six months. When changes occur, the crisis intervention plan shall be updated.

6.10.4.1 When updated the comprehensive crisis intervention plan shall be reviewed, signed, and dated by:

6.10.4.1.2 The case manager;

6.10.4.1.4 The physician,

**6.10.4.1.5 The clinical supervisor,
AND**

6.10.4.1.6 The consumer

6.11 Clinical Supervision

6.11.1 Each consumer case shall receive at a minimum:

6.11.1.1 Quarterly documentation of clinical supervision indicating:

6.11.1.1.1 A review of the consumer's progress;

6.11.1.1.2 A review of the consumer's treatment plan;

6.11.1.1.3 Recommendations for treatment;

6.11.1.1.4 Signature and date by the clinical supervisor.

6.11.2 When it is determined that a consumer must move from a higher level of care to a lower level of care, or from a lower level of care to a higher level of care, the clinical supervisor

will document the reasons for the level change as outlined in 6.11.1.1 of these standards.

6.12 Progress Notes

6.12.1A progress note shall be written for each clinical service provided to or on behalf of the consumer and include a summary of clinical service, clinical impressions and anticipated treatment in the following areas:

6.12.1.1 Psychotherapy when provided;

6.12.1.2 Supportive Counseling;

6.12.1.3 Crisis Intervention Services;

6.12.1.4 Group Counseling;

6.12.1.5 Physician/psychiatric services;

6.12.1.6 Use of on-call services.

6.12.1.7 Attempts to schedule and/or reschedule appointments.

6.12.1.8 All progress notes shall be written for each consumer record according to the policies and procedures of the CCCP.

6.12.1.9 When an individual does not receive psychotherapy, supportive counseling, crisis intervention services, group counseling, physician/psychiatric services or on call services, within a 30 day time period, a progress note will be entered in the record explaining the reasons for the limited contact.

6.12.1.10 Each consumer shall have at a minimum, one progress note once every 30 days.

6.13 Summary of Monthly Consumer Activity

6.13.1 The individual consumer record shall provide a monthly log documenting services provided to or on behalf of the consumer.

6.14 Discharge/Discharge Summary

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

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

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

6.14.3 Within 5 days of discharge from the program, a written discharge summary shall be completed for every consumer discharged.

6.14.4 The discharge summary shall include:

6.14.4.1 Date of discharge;

6.14.4.2 Reason for discharge;

6.14.4.3 Consumers status upon discharge;

6.14.4.4 Multiaxial DSM diagnosis;

6.14.4.5 Summary of progress toward treatment goals;

6.14.4.6 Aftercare/follow-up plan;

6.14.4.7 The consumer's forwarding address and/or telephone number.

6.14.5 The discharge summary shall be signed and dated by:

6.14.6 The case manager;

6.14.7 The physician;

**6.14.8 The clinical supervisor
AND**

6.14.8.1 The consumer when the discharged is planned.

6.15 Services

6.15.1 The CCCP program shall provide the following services as deemed necessary by assessment and prescribed by the individual treatment plan:

6.15.1.1 Psychiatric and substance abuse treatment;

6.15.1.1.1 Psychiatrist assessment as follows:

6.15.1.1.1.1 Face-to-face evaluation a minimum of every 14 days for the first 90 days of treatment and then every 30 days after for High Intensity Level consumers;

6.15.1.1.1.2 Face-to-face evaluation a minimum of every 30 days for Intermediate Intensity Level consumers;

6.15.1.1.1.3 Face-to-face evaluation a minimum of every 30 days for Lower Intensity Level consumers prescribed psychotropic medication or a minimum of every 60 days when the physician determines contact less than every 30 days is not needed. The physician must document the rationale for reduced frequency in the consumer file.

6.15.1.1.1.4 Face-to-face evaluation a minimum of every 90 days for Lower Intensity Level consumers not prescribed psychotropic medication.

6.15.1.1.2 Medication monitoring as follows:

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

6.15.1.1.2.1.1 Informed consent shall be obtained for each medication prescribed at the time it is prescribed.

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

6.15.1.1.2.2 Rationale for all changes in medication orders shall be documented in the physician's note.

6.15.1.1.2.3 All medication orders in the consumer's case record shall specify:

6.15.1.1.2.3.1 Name of the medication;

6.15.1.1.2.3.2 Dosage;

6.15.1.1.2.3.3 Route of administration;

6.15.1.1.2.3.4 Frequency of administration;

6.15.1.1.2.3.5 Signature of the physician prescribing the medication;

6.15.1.1.2.3.6 All known drug allergies.

6.15.1.1.2.4 Administration of medication by any method and/or the supervision of consumers in the self-administration of medication must be conducted and documented in conformance with the program's written policies and procedures for medication management.

6.15.1.1.2.5 Medication administration records shall contain the following:

6.15.1.1.2.5.1 Name of the medication;

6.15.1.1.2.5.2 Dosage;

6.15.1.1.2.5.3 Route of

administration;

6.15.1.1.2.5.4 Frequency of administration;

6.15.1.1.2.5.5 All known drug allergies;

6.15.1.1.2.5.6 Name of the person administering or assisting with the administration of medication.

6.15.1.1.2.5.7 Signature of the person administering or assisting with the administration of medication.

6.15.1.1.2.6 Staff shall monitor and document consumer compliance in following prescribed medication treatment and medication side effects to include the following:

6.15.1.1.2.6.1 Laboratory studies for all medications which require laboratory monitoring as recommended in the current Physician's Desk Reference;

6.15.1.1.2.6.1.1 Laboratory reports shall be reviewed and signed by the Physician or Registered Nurse within two (2) days of receipt.

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

6.15.1.1.2.6.3 AIMS (Abnormal Involuntary Movement Scale) shall be performed no less than annually to assess

clients at risk for developing Tardive Dyskinesia.

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

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

6.15.1.1.3 Case management;

6.15.1.1.3.1 A qualified CCCP staff person shall be designated responsible for maintaining a primary case manager relationship with each consumer and provide direct assistance in finding and maintaining:

6.15.1.1.3.1.1 Medical Services to include:

6.15.1.1.3.1.1.1 Physical as determined by these standards;

6.15.1.1.3.1.1.2 Dental evaluations completed by qualified medical staff and referral made when needed.

6.15.1.1.3.1.1.3 Eye evaluations completed by qualified medical staff and referral made when needed.

6.15.1.1.3.1.2 Safe/decent/affordable housing;

6.15.1.1.3.1.3 Entitlements;

6.15.1.1.3.1.4 Educational/vocational services;

6.15.1.1.3.1.5 Transportation;

- 6.15.1.1.3.1.6 Social skills training;**
- 6.15.1.1.3.1.7 Training in activities of daily living, including personal hygiene tasks, housecleaning, cooking, shopping, laundry, and managing money within income limits.**
- 6.15.1.1.3.1.8 Provision of support to The client, their family and other members of the consumer's social network to assist them and the consumer to relate in a positive and supportive manner including:**
 - 6.15.1.1.3.1.8.1 Education about the consumer's illness and their role in the therapeutic process;**
 - 6.15.1.1.3.1.8.2 Intervention to resolve conflict.**
 - 6.15.1.1.3.1.8.3 Referral to services for substance use illnesses when present.**

6.16 Required Frequency of Contact

6.16.1 Staff shall attempt (providing it does not interfere with the establishment of a therapeutic relationship) to provide the consumer with a minimum level of contact based on the assessed level of need as follows:

6.16.1.1 High Intensity Level:

6.16.1.1.1 Face-to-face contact with the staff psychiatrist a minimum of every 14 days in the first 90 days of treatment and a minimum of every 30 days there after.

6.16.1.1.2 Face-to-face contact with a clinician or case manager once every 7 days.

6.16.1.2 Intermediate Intensity Level :

6.16.1.2.1 Face-to-face contact with staff psychiatrist every 30 days.

6.16.1.2.2 Face-to-face contact with a clinician or case manager every 14 days.

6.16.1.3 Lower Intensity Level :

6.16.1.3.1 Face-to-face contact with a physician every 30 days if on psychotropic medication otherwise every 90 days. (See also Section 6.15.1.1.1.3 as related.)

6.16.1.3.2 Face-to-face contact with a clinician or case manager every 60 days.

6.16.2 The CCCP must make a good faith effort to reschedule missed appointments with consumers and the program physician during the same month the appointment is missed.

6.17 Minimum Standards for Certifying Living Arrangements for Consumers

6.17.1 Within the bounds of being safe, decent and affordable, housing shall be of the consumer's choice.

6.17.2 Housing (building) shall have a certificate of occupancy.

6.17.3 Housing shall contain smoke/heat detectors and conform to local fire safety codes.

6.17.4 The Community Support Services program shall certify to the Division that housing meets the above standards.

7 PSYCHOSOCIAL REHABILITATION CENTER (PRC) STANDARDS

7.1 PRC programs shall be operated only by providers of and in conjunction with a certified CCCP

7.2 The PRC facility shall operate at least 5-days per week for provision of Medicaid covered rehabilitative services. Medicaid covered rehabilitative services shall be provided at least from 8:30 a.m. to 1:30 p.m.

7.2.1 A substantial period of consumer participation in

the PRC program shall be required for the purpose of crediting the consumer with a full day of PRC Services.

7.2.1.1 Partial days shall not be additive for the purpose of billing for PRC Services.

- 7.3 The psychosocial rehabilitation center facility shall be organized to provide a maximum clinical staff to on-site consumer ratio of 1:10.**
- 7.4 Staff of both PRC and related CCCP shall meet jointly each morning to review the contacts with and status of each consumer during the previous day and to plan contacts for the current day. A clinical supervisor shall lead the daily meeting.**
- 7.5 Staff of both the PRC and the CCCP shall meet jointly at least weekly to conduct treatment planning and treatment plan reviews. A schedule of upcoming treatment plans and reviews shall be maintained. A clinical supervisor shall lead treatment planning and review meetings.**
- 7.6 The PRC program shall have a program coordinator who supervises the operation of the center and the services provided by its staff. The program coordinator shall be a clinician.**
- 7.7 The PRC program shall have among its staff individuals who are credentialed to conduct the following clinical skills: psycho-educational therapy; symptom education and self-management, vocational assessment and therapy; social skills training; and daily living skills training.**
- 7.8 When provision of PRC services is recommended, it shall be based on indications of the evaluation by the CCCP or the licensed Group Home for the mentally ill of deficits in symptom control, social skills and activities of daily living skills that are of sufficient severity to compromise the consumer's capacity for independent living and work. For each deficit identified, the PRC will undertake a comprehensive identification of the consumer's strengths and needs in relation to his/her functional deficits and of the possible modification of the environments in which the consumer needs to function.**
- 7.9 For consumers enrolled in the PRC program, the treatment plan shall contain specific rehabilitation goals and interventions related to their participation in the center program. The interventions, with their expected frequency and duration, shall**

be contained within the consumers' treatment plans. The treatment plan shall be prepared on forms approved by the Division and shall be signed by the primary therapist, clinical supervisor and physician.

7.10 The program shall nurture the consumer's control over the use of the PRC facility as a recreational and community resource. The facility shall be available to consumers as a drop-in center, a location for self-help and mutual support meetings, and a resource to mount community service projects. Such functions shall be cooperatively planned by program staff and consumers, with maximum opportunity for consumer involvement in decision making. There shall be a clear separation between the rehabilitative function of the center and its role as a hub for CCCP consumers' social networks.

7.11 In the PRC program, rehabilitative therapy will be based within the facility and focus on the acquisition or relearning of skills needed for the consumer to live more independently with the assistance of the Continuous Treatment Team program.

7.12 The PRC shall provide the following services:

7.12.1 Instrumental Life Skills Therapy Services - individual and/or group therapy to provide a transitional, individually time-limited, systematic treatment/training program which assists consumers toward their optimal level of community and vocational development. Utilizing simulated work, the intent of the service is to assist consumers to understand the meaning, value, and demands of work and to learn or reestablish habits and behaviors prerequisite to holding a job.

7.12.1.1 Independent Living Assessment - Work units will be designed to allow the consumer to choose a work function. The primary goals are to help a consumer develop basic work skills, develop co-worker relationships, learn to deal with stress related to task performance activities and to feel a sense of accomplishment and reward to reinforce one's ability in productive activities. The work units are also designed to provide basic acquisition of living skills in order to transfer this knowledge and experience to the independent community living environments.

7.12.1.2 Work Adjustment Skills Training -

treatment/training service utilizing individual and group work to provide work-related activities to assist individuals in developing functional capacities, as required, in order to assist individuals toward their optimum level of vocational development.

7.12.1.3 Vocational Evaluation Services - will be provided in collaboration with Vocational Rehabilitation Services to provide a comprehensive process that systematically utilizes work, either real or simulated, as a focal point for assessment and vocational exploration, the purpose of which is to assist the person in vocational development and decision making.

7.12.1.4 Job Placement Services - will provide assistance to consumers to identify, obtain and/or maintain employment commensurate with their vocational, social, psychological, and medical needs, and their abilities.

7.12.2 Psycho-educational Therapy Services either in a group and/or individual format will provide consumers with knowledge of the biological, psychological and social elements of their illnesses; improve their ability to cope with and control their symptoms and teach skills associated with compliance with prescribed medical treatment.

7.12.2.1 Control Symptoms - Supportive counseling or psychotherapy to assist the consumer to understand the nature and dynamics of his/her mental illness, to recognize symptoms, to follow prescribed medication therapy, and to exercise self-control over symptoms and environmental factors that affect symptoms.

7.12.2.2 Assess/Monitor Well Being - Determination of the individual's strengths and needs both at intake and continually throughout the treatment process. Areas of assessment will include mental status, medication, general health, self-care, support network, family consultation, employment capabilities and training needs.

- 7.12.2.3 Medication Education - individual and/or group contacts with the consumer to assess medication compliance by non-medical staff according to DADAMH standards. After medication counseling services, compliance assessment will include the documentation of compliance and medication effects and side-effects and as appropriate reported to prescribing physician.**
- 7.12.2.4 Alcohol/Drug Abuse Education - services provided by the interdisciplinary team on individual and group basis to provide appropriate assessment, referral, and treatment services as reflected in the program's capacity to meet the individual needs of the consumer.**
- 7.12.3 Social Skills Training - direct service to the consumer, individually or in small groups, in the context of a planned and clinically relevant teaching/therapeutic structure to improve their capacity to establish social skills in the community.**

 - 7.12.3.1 Personal and Social Adjustment Services- individual and/or group therapy in which functional skills are developed and maintained and which provide broad opportunities for valued adult roles in the community. Treatment planning will be goal-oriented to maximize the consumer's independent functioning through the provision of therapy and training in such areas as self-care, physical and emotional maturation, socialization, communication, and cognitive, leisure, and pre-vocational skills.**
 - 7.12.3.2 Interpersonal Skills Assessment and Development - direct service to the consumer, individually or in small groups, in the context of a planned and clinically relevant teaching/therapeutic structure to develop and maintain interpersonal relationships, to effectively represent one's needs and self-interests to others, to negotiate and resolve disagreements with others and to develop mutually supportive relationships with peers.**

7.12.3.3 Recreational Therapy Activities - social/recreational services designed to help consumers to strengthen interpersonal skills and have healthy leisure experiences which provide a sense of personal satisfaction.

7.12.4 Activities of Daily Living Training - direct service to the consumer, individually or in small groups, in the context of a planned and clinically relevant teaching/therapeutic structure to build or improve capabilities for performing the instrumental tasks of independent living.

7.12.4.1 Household Activities Training - training in activities of daily living including individual support, problem solving and supervision in home and community-based settings to assist clients in order to carry out personal hygiene tasks; carry out household activities including house cleaning, cooking, shopping and laundry; and manage money within income limits.

7.12.4.2 Community Resources Training - use community resources such as transportation, social services, medical services; locate, finance and maintain decent, safe, and affordable housing/living arrangements; and relate to landlords, neighbors and others effectively.

7.12.4.3 Adult Education - direct service to the consumer, individually or in small groups, in the context of a planned and clinically relevant teaching/therapeutic structure to improve general knowledge and qualifications for employment (e.g. GED preparation) or self-help (e.g. financial management and health maintenance). Adult Educational Services may be provided in collaboration with the local Adult Continuing Education Service in order to promote and encourage continuation of adult education and completion of basic skill learning required to maintain community tenure.

7.12.5 Community Social Support Services - will be

provided by working with the consumer's family, friends, employer, and others with significant ties to the consumer in order to advocate with the consumer in the development of community supports related to locating, applying for, and using resources such as benefit programs; employment programs; housing options/resources; assistance with financial management; mental health services; medical, dental and other health care services; educational, recreational and social activities.

7.12.5.1 Consumer Advocacy - Supportive counseling to assist the consumer to resolve interpersonal conflict, e.g. meeting jointly with consumer and family member to resolve a conflict disrupting the stability of the living arrangement; assisting the consumer to analyze and come to terms with the reasons for termination from employment; accompanying the consumer to a meeting with the landlord to negotiate a settlement to a landlord tenant dispute.

7.12.5.2 Service Linkage - direct assistance to or on behalf of the consumer in obtaining entitlement and health and social services.

7.12.5.3 Resource Management - direct assistance to or on behalf of the consumer in obtaining necessities (e.g. clothing, appliances etc.) and managing funds (e.g. budgeting, bill paying, etc.).

7.13 Required Frequency of Psychosocial Rehabilitation Center Home and Community-Based Contact

7.13.1 Consumers of PRC services operated by or in conjunction with a CCCP shall attend the program a minimum of two days per week. Attendance will count toward a requirement of five face-to-face contacts per week during the first six months following admission. After the initial six months, like other CCCP consumers, those enrolled in PRC services shall be provided a minimum of one face-to-face contact in a home or community-based setting per week. At least one contact per month shall be in the consumer's home. Recurrent deviation from these minimum contact requirements must be clinically justified by the program physician in

the consumer's treatment record.

8. RESIDENTIAL REHABILITATION FACILITY (RRF) STANDARDS

8.1. A Residential Rehabilitation Facility must be licensed as a Mental Health Group Home by the Delaware Division of Long Term Care Residents Protection (DLTCRP).

8.1.1. The DSAMH conducts surveys in cooperation with DLTCRP for licensure of Mental Health Group Homes.

8.1.2 Mental Health Group Home Licensing standards may be obtained from DLTCRP (telephone 302- 577-6661).

9. ORGANIZATIONAL STANDARDS

9.1 Community Support Services programs shall establish an advisory committee, which meets at least quarterly and includes program consumers and family members of consumers within its membership. The function of the advisory committee shall be to ensure consumer and family participation in the process of setting and evaluating the values, mission, goals, objectives and service strategies of the program and to assist the program in representing its interest to the community in which it operates.

9.1.1 The advisory committee shall have written rules governing the conduct of its meetings which specify at least the following:

9.1.1.1. Its authority and duties;

9.1.1.2. Officers and committees;

9.1.1.3. Criteria, types, methods of membership;

9.1.1.4. Frequency of meetings;

9.1.1.5. Attendance requirements.

9.1.2 Minutes of advisory committee meetings shall be kept and shall include the following:

9.1.2.1. Date of meeting;

9.1.2.2. Attendance;

9.1.2.3. Topics discussed;

- 9.1.2.4. Decisions reached;
- 9.1.2.5. Actions planned or taken;
- 9.1.2.6. Reports from sub-committees.

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

- 9.2.1. They shall maintain a Certificate of Occupancy;
- 9.2.2. They shall meet all applicable fire and life safety codes;
- 9.2.3. They shall be maintained in a clean and safe condition;
- 9.2.4. They shall provide rest rooms maintained in a clean and safe condition available to consumers, visitors and staff;
- 9.2.5. They shall be accessible to the consumer served;
- 9.2.6. They shall provide a smoke free environment.

10 ADMINISTRATIVE STANDARDS

10.1 Consumer Records

- 10.1.1 There shall be a treatment record for each consumer that includes sufficient documentation of assessments, treatment plans and treatment to justify Medicaid participation and to permit a clinician not familiar with the consumer to evaluate the course of treatment.
- 10.1.2 There shall be a designated consumer record manager who shall be responsible for the maintenance and security of consumer records.
- 10.1.3 The record keeping format and system for purging shall provide for consistency, facilitate information retrieval and shall be approved by the Division.
- 10.1.4 Consumer treatment records shall be kept confidential and safe-guarded in a manner consistent with the requirements of the Health Insurance Portability and Accountability Act on 1996, 45 C.F.R. Parts 160 and 164, and 42 C.F.R Part 2 governing the confidentiality of alcohol and drug patient records (if applicable).

10.1.5 The active consumer record shall contain the following:

- 10.1.5.1. A minimum of the program's last 12 months treatment records for the consumer;**
- 10.1.5.2. An up-to-date face sheet;**
- 10.1.5.3. Consent to treatment signed by the consumer;**
- 10.1.5.4. Consent to any occasion of release of information**
- 10.1.5.5. Documentation that the consumer has been informed of his/her rights;**
- 10.1.5.6. Documentation that the consumer has been provided with information regarding the process by which grievances can be addressed;**
- 10.1.5.7. Copies of any grievances filed by the consumer;**
- 10.1.5.8. Reports from all examinations, tests and clinical consults;**
- 10.1.5.9. Hospital discharge summaries;**
- 10.1.5.10. Comprehensive medical psychosocial evaluation;**
- 10.1.5.11. Comprehensive treatment plan/treatment plan updates;**
- 10.1.5.12. Crisis intervention plan and updates;**
- 10.1.5.13. Summary of monthly consumer activity;**
- 10.1.5.14. Progress notes;**
- 10.1.5.15. Documentation of clinical supervision;**

10.1.5.16. Medication records;

10.1.5.17. Discharge documentation.

10.2 Procedure Manual

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

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

10.2.1.2. Referral policies and procedures that facilitate consumer referral;

10.2.1.3. Detailed instructions for assessment, service planning and documentation procedures;

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

10.2.1.4.1 Prescribing medication;

10.2.1.4.2 Storage of medication;

10.2.1.4.3 Handling of medication;

10.2.1.4.4 Distribution of medication;

10.2.1.4.5 Dispensing of medication;

10.2.1.4.6 Disposing of medication;

10.2.1.4.7 Recording of medication used by consumers.

- 10.2.1.5 Policies and procedures for handling on-call responsibilities and consumer emergencies;
- 10.2.1.6 Detailed instructions for application to and communication with entitlement authorities;
- 10.2.1.7 Policies and procedures for sharing of information about consumers with family members or others;
- 10.2.1.8 Policies and procedures regarding committing and handling financial resources of the program;
- 10.2.1.9 Policies and procedures regarding the management of consumer's funds for whom the program has been designated payee;
- 10.2.1.10 Policies and procedures for the receipt, consideration and resolution of consumer complaints and/or grievances regarding treatment decisions and practices or other program activities.
- 10.2.1.11 Other policies and procedures as maybe promulgated or required by the Division and/or DSS/DMAP.

10.3 Personnel Management

10.3.1 The Community Support Services Programs or parent organization shall maintain an up-to-date Personnel Policies and Procedures Manual and make it readily available for reference by the program staff. The Manual will include:

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

10.3.1.1.1 The Americans with Disabilities Act and the Vocational Rehabilitation Act of 1973, Sections 503 and 504

**prohibiting discrimination
against the handicapped;**

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

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

**10.3.1.1.4 Age discrimination Act of
1975 prohibiting discrimination
based on age;**

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

**10.3.1.2. Policies and procedures for interviews
and selection of candidates including
verification of credentials and references;**

**10.3.1.3. Policies and procedures for employee
performance appraisal;**

10.3.1.4. A code of ethics;

**10.3.1.5. Conditions and procedures for
termination of employment;**

**10.3.1.6. Conditions and procedures for grievances
and appeals;**

**10.3.1.7. An annual staff development plan
which shall include:**

**10.3.1.7.1. Provisions for orientation of
paid staff, student interns
and volunteers. Orientation**

shall include:

- 10.3.1.7.1.1. Review of these standards;**
- 10.3.1.7.1.2. Review of the program's procedures and personnel manuals;**
- 10.3.1.7.1.3. Review of DSSS Policy Memorandum #46;**
- 10.3.1.7.1.4. Review of section 5161 of Title 16;**
- 10.3.1.7.1.5. Review of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164;**
- 10.3.1.7.1.6. Review of 42 C.F.R. Part 2.**

- 10.3.1.7.2. Provisions for continuing education of staff;**

- 10.3.1.7.3. Provisions for regularly scheduled clinical supervision which teach and enhance the clinical skills of staff including:**
 - 10.3.1.7.3.3 Weekly team meetings led by the clinical supervisor during which assessments, treatment plans and progress toward treatment goals are**

reviewed and staff receive direction regarding clinical management of treatment issues.

10.3.1.7.3.4 Individual face-to-face sessions between the clinical supervisor and staff to review cases, assess performance and give feedback;

10.3.1.7.3.5 Individual, side-by-side sessions during which the clinical supervisor attends clinical sessions conducted by staff to assess performance, teach clinical skills and give feedback.

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

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

10.3.1.10. Agency policies regarding compensation including:

10.3.1.10.1 salary ranges, salary increases, and payroll procedures;

10.3.1.10.2 Use of personal automobile for program activities;

10.3.1.10.3 Reimbursement for work related expenses;

10.3.1.10.4 Description of employee benefits.

10.4 Quality Assurance Program

10.4.1. The Community Support Services Programs shall prepare an annual quality assurance plan, which shall be subject to approval by the -Division. A clinician employed by the program or parent organization shall be designated quality assurance coordinator. The provider shall establish the following quality assurance mechanisms which shall be carried out in accordance with the quality assurance plan: a concurrent utilization review process; a retrospective quality assurance review process; a process for clinical care evaluation studies; and a process for self-survey for compliance with the certification standards.

11 WAIVER OF PROVISIONS

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

11.1.1 Waivers issued by the Director shall be in writing and shall specify the maximum duration of the waiver's effect.

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

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

12.0 DEEMED STATUS

12.1 Programs with Three-Year Accreditation from CARF or Full Accreditation from JCAHO may qualify for Deemed Status.

- 12.2 Programs with One-Year Accreditation from CARF or Provisional Accreditation from JCAHO may qualify for Deemed Status at the discretion of the Division Director.**
- 12.3 Programs with Provisional Accreditation from CARF or Conditional Accreditation from JCAHO will not qualify for Deemed Status.**
- 12.4 Programs that are accredited as part of a merger, consolidation or acquisition must submit verification that CARF and/or JCAHO will extend accreditation to the new entity.**
- 12.5 Notification of Audit:**
- 12.5.1 Programs must inform DSAMH of all CARF and/or JCAHO visits whether announced or unannounced. The Licensing and Medicaid Certification Unit should be notified in writing of a scheduled visit no less than 30 days prior to the visit. The Licensing and Medicaid Certification Unit should be notified by phone or email of an unannounced visit within 24 hours of the first day of the visit.**
- 12.6 Reporting to DSAMH**
- 12.6.1 Programs must notify DSAMH of any immediate threat to life that is discovered by CARF and/or JCAHO during the visit within 24 hours of the day the threat to life is discovered.**
- 12.6.2 Programs must report all other *significant events or sentinel events* to DSAMH within 24 hours accompanied by the investigation report; action plan and action plan follow up activity reports prepared according to CARF and/or JCAHO.**
- 12.6.3 Programs must submit to DSAMH any corrective action to address *significant events and/or sentinel events* at the same time they are submitted to CARF and/or JCAHO.**
- 12.6.4 Programs must submit to DSAMH any other correspondence required by CARF and/or JCAHO during the course of the Accreditation period and/or between each CARF and/or JCAHO review.**
- 12.7 Deemed Status Revocation**

- 12.7.1 Deemed status standing can be revoked by DSAMH at any time, but specifically when:
 - 12.7.1.1 A program is unsuccessful in receiving Three-Year, Full, or One-Year Accreditation from CARF and/or JCAHO;
 - 12.7.1.2 In response to a *significant event* or *sentinel event*;
 - 12.7.1.3 When reporting to DSAMH does not occur in according with the time table established above;
 - 12.7.1.4 Following a survey by DSMAH when it is determined that the program is not operating under the DSAMH certification standards.
- 12.7.2 Once revoked, a program must wait 1 year before reapplying for Deemed Status. DSAMH must conduct a site review before restoring Deemed Status.

12.8 Program Exemptions:

- 12.8.1 Programs who are successful in obtaining Deemed Status are exempt from the following CCCP standards:
 - §2.0 in its entirety
 - § 6.2.6 through §6.2.9
 - § 6.5.1 and §6.5.2 and §6.5.4
 - §6.6 in its entirety
 - §6.7.1 and §6.7.2.1 including subsections 6.7.2.1.1 through 6.7.2.1.12
 - §6.9.1 in its entirety
 - §6.9.2.1 and §6.9.2.2 including all subsections.
 - §6.12.1 including subsections 6.12.1.1 through 6.12.1.7
 - §6.14.4 including all subsections.
 - § 9.0 in its entirety
 - §10.2 in its entirety §10.3.1 through 10.3.1.7

§10.3.1.8 through 10.3.1.10

§10.4 in its entirety.