Program for Assertive Community Treatment (PACT)

Providers contracted for this service are expected to comply with all requirements of these service-specific performance specifications.

Program for Assertive Community Treatment (PACT) is a service for adults with the most challenging and persistent problems, related to psychiatric illness, who have not responded to more traditional services. PACT entails the provision of an array of clinical, rehabilitative, and recovery-oriented services, delivered by a community-based, mobile, multi-disciplinary team of professionals, paraprofessionals, and peer specialists, to support a Member's personal recovery journey.

PACT multi-disciplinary teams provide active, flexible, ongoing, and community-based psychiatric treatment, assertive outreach, rehabilitation, and support. The goal of services is not only stability but community integration and quality of life. Services are not time limited. The team aids Members in maximizing their recovery; ensuring Member-directed goal setting; assisting Members in gaining a sense of hope and empowerment; and providing assistance in helping Members become better integrated within the community. PACT services measure the following key outcomes for Members:

i. Self-determination, independence, and empowerment;
ii. Life satisfaction;
iii. Symptom relief and self-management;
iv. Community tenure/fewer incidents of relapse;
v. Housing stability and quality;
vi. Employment; and
vii. Family satisfaction

PACT services are provided in natural community settings and are available, as needed by the Member, 24 hours a day, 7 days a week, 365 days a year. PACT directly provides clinical services and is not merely a case management or referral program. PACT provides all clinical non-acute behavioral health and substance use disorder interventions in addition to linking members to community-based, self-help resources and providing direct rehabilitation, vocational, and housing related services.

PACT teams comply with the following National Program Standards*:

**These National Standards for PACT Teams, June 2003, were developed with support from the U.S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Community Support Branch, through grant #SSM52579-4.*

The ACT Standards is a companion document to A Manual for ACT Start-Up: Based on PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses, written with support from the National Alliance on Mental Illness Assertive Community Treatment Technical Assistance Center.

Components of Services

1. PACT staff provides crisis assessment, intervention, and emergency services 24 hours a day, 7 days a week, 365 days per year, including telephone and face-to-face contact during the program's operating hours. After hours, the program provides Members with an emergency phone number to access a clinician either directly or via an answering service. Both during and after operating hours, the responding clinician conducts a brief assessment and intervention by phone. Based upon this assessment, the provider may refer the Member, if needed, to Adult Mobile Crisis Intervention (AMCI), formerly Emergency Service Program (ESP) for emergency behavioral health crisis assessment, intervention, and stabilization. An answering machine or answering service directing callers to call 911, call the nearest AMCI, or to go to a hospital Emergency Department (ED), is not sufficient. Services may be provided in collaboration with the local AMCI, as appropriate; however, local AMCI services shall augment, not substitute for, PACT on-call telephone and face-to-face responsibility.
2. The PACT team operates an after-hours on-call system. PACT staff experienced in the program and skilled in crisis-intervention procedures are on call and available to respond to Members both by telephone and in person. Staff is prepared to accompany Member to crisis services, when necessary, to be with the Member if/when police or AMCI are called.
3. Care coordination is a core function provided within the PACT team. Supported by the PACT team leader, the PACT primary care manager is primarily responsible for the following activities. He/she also coordinates and monitors the activities of the PACT staff who have ongoing responsibility to assess, plan, and deliver treatment, rehabilitation, and support services. PACT staff who are part of the Member's "mini team" share these tasks with the primary care manager and are responsible for performing the tasks when the primary care manager is not available.
   a. Develops an ongoing relationship with the Member that is based on mutual trust and respect. This relationship is maintained whether the Member is in a hospital, in the community, or involved with other agencies (e.g., in a detox center, involved with corrections, etc.);
   b. Works in partnership with the Member to develop a recovery-focused treatment plan;
   c. Provides individual supportive therapy and works with the Member around symptom management;
   d. Makes immediate revisions to the treatment plan, in conjunction with the Member, as his/her needs and circumstances change;
   e. Is responsible for working with the Member on crisis and relapse prevention planning and crisis prevention; works with the Member, the mini-team, and the team, to evaluate the effectiveness of the crisis plan and relapse plan and makes adjustment as needed;
   f. Coordinates and monitors the documentation required in the Member's health record;
   g. Advocates for the Member's rights and preferences; and
   h. Collaborates with and involves family and natural supports in treatment.
4. Symptom assessment, management, and individual supportive therapy are provided to: engage the Member in identifying symptoms and their impact; assist Members to address the

distressing and disabling problems associated with psychotic symptoms and the dysregulation resulting from trauma; help ease the emotional pain associated with having a serious mental illness (e.g., severe anxiety, despair, loneliness, unworthiness, and depression); and assist Members with symptom self-management efforts that may reduce the risk of relapse and minimize emotional distress.

These activities, which may be carried out by the team psychiatrist, nurses, and/or other PACT staff, include:

a. Ongoing assessment of the Member's symptomatology, progress in adopting life roles, increase in independence, quality of life factors, and his/her response to treatment;
b. Education on mental health, substance use disorders, and psychopharmacology (efficacy and side effects);
c. Encouragement of symptom self-management practices directed to help the Member identify symptoms and their occurrence patterns and develop methods (internal, behavioral, adaptive) to help lessen their effects, e.g., specific cognitive behavioral strategies directed at fostering feelings of self-control;
d. Supportive psychotherapy to address the psychological trauma of having a psychiatric condition;
e. Psychological support to the Member, both on a planned and an as-needed basis, to help him/her accomplish personal goals and to manage the stresses of day-to-day living; and
f. Assistance in exploring various approaches to symptom management, self-regulation, and wellness such as physical activity, yoga, nutrition, meditation, and WRAP plans.

5. The program provides for medication prescription, administration, adjustment, monitoring, education, and related documentation.
   a. The PACT team psychiatrist:
      i. Conducts a psychiatric assessment of each Member, including his/her psychiatric symptoms and behaviors and an understanding of how the Member wants the medications to benefit him/her;
      ii. Prescribes medication and provides ongoing medication management with the goal of both symptom management and supporting the Member's goals;
      iii. Educates the Member regarding his/her psychiatric condition and the effects and side effects of medication prescribed to regulate it;
      iv. Monitors, treats, and documents any medication side effects; and
      v. Regularly reviews and documents the Member's psychiatric symptoms as well as his/her response to prescribed medication. All PACT team members also assess and document the Member's symptoms and behavior in response to medication and monitor for medication side effects.
   b. The PACT program establishes documented medication policies and procedures that identify processes to:
      i. Facilitate Member education and informed consent about medication;
      ii. Record physician orders;
      iii. Order medication;

iv. Arrange for all medication related activities to be organized by the team and documented in the Member's weekly schedule and daily staff assignment schedules;
v. Provide security for storage of medications, including setting aside a private area designated for set up of medications by the team's nursing staff; and
vi. Administer medications to Members, as needed.

6. Services are provided to support Member's health and wellness. PACT recognizes the connection between physical health and mental health and the prevalence of co-occurring illnesses among people receiving mental health services. Members are assisted in:
   a. Identifying lifestyle changes that may enhance their physical health and well-being and are realistic;
   b. Support in making lifestyle changes as desired by the Member;
   c. Assistance in managing medication regimens for physical illnesses;
   d. Education about health issues as needed;
   e. Support in obtaining and keeping medical appointments;
   f. Support in self-advocacy with health care providers as needed; and
   g. Support during health care appointments as needed.
7. Substance use disorder services include, but are not limited to, individual and group interventions to assist Members to:
   a. Identify substance use patterns and impacts;
   b. Recognize the relationships among substance use, psychiatric conditions, trauma, the use of substances for self- medication, and psychotropic medications;
   c. Monitoring and managing the possible interaction of prescribed medication and other substances used by the Member;
   d. Increase awareness and hope for the possibility of change;
   e. Utilize motivational interviewing;
   f. Identify the best change action specific to his/her unique circumstances;
   g. Identify and utilize strategies for relapse prevention to achieve periods of sobriety and stability;
   h. Renew the processes of contemplation, determination, and action;
   i. Develop linkages with self-help groups such as Double Trouble and Dual Recovery programs, as well as Alcoholics Anonymous and Narcotics Anonymous; and when needed, accompany the Member to a self-help meeting to provide support and integrate the learning into the person's life;
   j. Access substance use disorder treatment services outside the scope of PACT when needed, such as Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7); and
   k. Use evidence-based treatments such as Integrated Dual Diagnosis Treatment for groups as indicated.
8. Housing services and support are provided to help Members obtain and keep housing consistent with their recovery objectives. PACT staff are familiar with the availability and workings of affordable housing programs. PACT staff develop and maintain working relationships with local housing agencies from whom housing units, any necessary rental

subsidies, and other available housing-related services or resources may be accessed on behalf of Members.

9. PACT housing services and support include but are not limited to assisting Members in:
    a. Finding apartments or other living arrangements;
    b. Securing rental subsidies;
    c. Developing positive relationships with landlords and neighbors;
    d. Executing leases;
    e. Moving and setting up the household;
    f. Meeting any requirements of residency;
    g. Carrying out household activities (e.g., cleaning);
    h. Facilitating housing changes when desirable or necessary; and
    i. Providing temporary rental subsidies and funds for rental deposits, as needed and within budgetary limits.
10. Vocational and educational supports and services are provided, in collaboration with clubhouses, employers, academic or training institutions, and other resources, to help Members find and maintain educational opportunities and/or employment in community-based sites that include, but are not limited to, the following:
    a. Assessment of educational and job-related interests and abilities, through a complete education and work history assessment, as well as on-site assessments in educational settings and/or community-based jobs;
    b. Assessment of the effect of the Member’s psychiatric condition on employment or educational learning, with identification of specific behaviors that may interfere with his/her work or learning performance, and development of interventions to reduce or eliminate those behaviors;
    c. Assessment and management of medication side effects which may interfere with work;
    d. Development of an ongoing supportive educational or employment rehabilitation plan to help each Member establish the skills necessary to find and maintain a job or to remain in an educational setting;
    e. Benefits counseling expertise to help Members understand how gainful employment will affect Social Security Administration (SSA) disability payments and health coverage and address work incentive benefits available through SSA and other agencies;
    f. Individual supportive therapy to assist Members to identify and manage psychiatric symptoms that may interfere with work performance or learning;
    g. Educational learning or on-the-job or work support, including crisis intervention, as needed;
    h. Educational learning or work-related supportive services, such as assistance with grooming or personal hygiene, securing of appropriate clothing, wake-up calls, transportation, etc.;
    i. Building of cooperative relationships with publicly funded “mainstream” employment, education, training, and vocational rehabilitation agencies/organizations in the community (e.g., Mass. Rehabilitation Commission, the Department of Labor and Workforce Development Career Centers, SSA programs);

   j. Job development through community linkages. Each employment specialist has designated time in his/her schedule for job development activities, and each program is expected to develop job development/marketing materials to use with local businesses; and
   k. Utilization of motivational interviewing and linking to the Member's goals and dreams to encourage him/her to obtain education and/or work.

11. Services to support socialization, interpersonal relationships, recreation, leisure-time activities, and peer support help Members structure their time, maintain, and expand a positive social network, reduce social isolation, practice social skills, and receive feedback and support. These supports engage with the Member to:
    a. Assess and identify his/her joys, abilities, and accomplishments in the present and in the past, and what he/she would like to occur in the future;
    b. Identify the Member's beliefs and meanings, and determine what role they play in his/her overall well-being;
    c. Identify and address potential obstacles to establishing positive social relationships (e.g., shyness; anxiety; his/her expectations for success and failure; anticipation of stigma related to their illness);
    d. Give side-by-side support and coaching, as needed, to build Member's confidence and success in relating to others;
    e. Provide supportive individual therapy (e.g., problem-solving, role- playing, modeling; and support), social-skill teaching; and assertiveness training;
    f. Make connections to peer advocates or peer supports;
    g. Help Member make plans with friends for social, spiritual, and leisure time activities within the community; and
    h. Identify culturally specific community resources which may be of interest to the Member and help foster that connection.
12. Services to support activities of daily living (ADLs) in community-based settings include individualized assessment, problem-solving, self-advocacy training, side-by-side assistance and support, skills training, ongoing supervision (e.g., prompts, assignments, monitoring, encouragement), and environmental adaptations to assist Members to gain or use the skills required to:
    a. Carryout personal care and grooming tasks;
    b. Perform activities, including making or obtaining nutritional meals, housekeeping, grocery shopping, and laundry;
    c. Procure necessities such as a telephone, microwave, etc.;
    d. Find housing that is safe and affordable through relationships with local housing authorities, housing alliances, and local landlords;
    e. Develop or improve skills to budget money and resources;
    f. Use available public transportation resources;
    g. Obtain and utilize a Primary Care Provider (PCP) and dentist (e.g., annual physicals, dental services, etc.); and
    h. Access other needed community resources such as legal advocacy and representation, social services, and financial entitlements.

13. The program provides education, support, and consultation to Member families and other supports, with the Member's consent, including:
    a. Education about the Member's condition and the role of the family or significant others in the Member's recovery process;
    b. Intervention to mediate and resolve conflict; and
    c. Ongoing communication and collaboration, face-to-face or by telephone, between the PACT team and the family or significant others.
14. PACT programs provide Culturally and Linguistically Competent Services where there is an integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the culture and language of the individual receiving services so that there is an increase in the quality and appropriateness of health and behavioral care and outcomes. PACT team staff is aware of each Member's help-seeking/accepting behaviors and explanations for emotional crisis, especially where these maybe culturally influenced.
15. PACT programs must have physical sites that allow for easy access for Members and families, including access for persons who have physical handicaps. Access includes but is not limited to access to public transportation and parking.
16. PACT programs flexibly provide multiple contacts per week with Members. PACT services are assertive. Contact occurs as often as necessary to meet an Member's needs and with consideration to an Member's preference. Contacts may be as frequent as two to three times per day, seven days per week. Many, if not all, staff share responsibility for addressing the recovery needs of all Members requiring frequent contacts. Each contact is purposeful and related to the Member's priorities as reflected in his/her treatment and recovery plans.
17. PACT services predominantly occur outside program offices in the community, within the Member's life context, including at home and other settings.
18. PACT teams provide treatment, rehabilitation, and support activities 7 days a week. On Monday through Friday, the team operates a minimum of 12 hours per day through two overlapping 8-hour shifts. On each weekend day and holiday, the team operates for 8 hours with at least two staff providing services. Member meetings and purposeful activity related to his/her goals are expected to occur 7 days a week and across shifts.
19. Psychiatric consultation is available 24 hours per day, 7 days per week, 365 days per year, including evenings, weekends, and holidays.
20. The PACT program develops and maintains policies and procedures consistent with all applicable state standards and covering:
    a. Informed consent for treatment, including medication;
    b. Client rights;
    c. Admission and discharge (e.g., admission criteria and process; discharge criteria, process, and documentation);
    d. Personnel (e.g., required staff, staffing ratios, qualifications, orientation, and training);
    e. Hours of operation and coverage, service intensity, staff communication and planning emphasizing a team approach, and staff supervision;
    f. Assessment and treatment processes and documentation (e.g., comprehensive assessment, treatment planning, progress notes);

g. Treatment, rehabilitation, and support services;
h. Client medical record maintenance;
i. Management of client funds, as applicable;
j. Program evaluation and performance (quality assurance);
k. Procedures for compliance with applicable state and federal laws, including all Equal Employment Opportunity (EEO)/Affirmative Action (AA) requirements. Contractors must comply with the Americans with Disabilities Act; and
l. Medication storage and delivery.

Staffing Requirements

1. The provider complies with the staffing requirements of applicable licensing bodies, the staffing requirements in the SWH service-specific performance specifications, and the SWH credentialing criteria.
2. At least 60% of the total non-MD, direct-care staff, including the team leader/program director, are mental health professionals with the following qualifications:
   a. Degrees in one of the following disciplines: master's or doctoral nursing, social work, rehabilitation counseling, psychology, or mental health counseling; nurses and/or registered nurses with a diploma;
   b. Associate's and bachelor's degree, and registered occupational therapists;
   c. Clinical training, including internships and other supervised practical experiences in a clinical or rehabilitation setting;
   d. Clinical work experience with persons with serious mental illness; and
   e. License or certification per the applicable Massachusetts regulations.
3. A full-time team leader/program director is the clinical and administrative supervisor of the team and functions as a practicing clinician on the team. The team leader/program director has at least a master's degree in nursing, social work, psychiatric rehabilitation, psychology, or mental health counseling, or is a psychiatrist who meets credentialing criteria. He/she also has at least two years of direct experience treating persons with serious mental illness, including at least one year of program management or supervisory experience in a mental health setting.
4. A psychiatrist who meets credentialing criteria works in the program on a full-time or part-time basis for a minimum of 20 hours per week for 60-80 Members. The psychiatrist, in collaboration with the team leader/program director oversees the clinical operations of the team. The psychiatrist provides clinical services to all Members, works with the team leader/program director to monitor each Member's clinical status and response to treatment, supervises staff delivery of services, provides side-by-side supervision in the community during routine and crisis interventions, and directs psychopharmacological and medical treatment.
5. If availability of the PACT team's psychiatrist during all hours is not feasible, alternative short-term psychiatric back up is arranged (e.g., mental health center psychiatrist, emergency room psychiatrist, etc.). A full-time, master's-level lead clinician assumes some formal leadership of the team. He/she assists the psychiatrist and team leader/program director in

providing clinical leadership during treatment planning meetings, assuming assignment of the more challenging mini-team assignments, assisting with the provision of side-by-side supervision, and working with the lead registered nurse. The lead clinician provides support and back-up to the team leader/program director in his/her absence.

6. At least two full-time registered nurses work in the program, including one lead registered nurse who works side-by-side with the team leader/program director and psychiatrist to ensure systematic coordination of medical treatment and the development, implementation, and fine-tuning of the medication policies and procedures. If two nurses are employed, there must be at least three master's-level specialists in addition to the lead clinician. It is recommended that an additional employment specialist, or other specialist depending upon the anticipated needs of the Members, be hired as the additional master's- level specialist.
7. At least one full-time employment specialist works in the program with a master's degree in rehabilitation counseling or related field and at least one year of supervised experience in providing individualized job development and supported employment on behalf of persons with mental illness
8. At least one full-time addiction specialist works in the program with a master's degree in social work, psychology, counseling or related field; certification as an addictions counselor; and at least one year supervised experience providing substance use disorder treatment interventions to persons with co-occurring psychiatric and addictions disorders; or with a bachelor's degree in mental health, human services, or related field and at least two years supervised experience providing substance use disorder treatment interventions to persons with co-occurring psychiatric and addictions disorders
9. PACT staffing also includes bachelor's-level and paraprofessional mental health workers who carry out rehabilitation and support functions.
    a. A bachelor's-level mental health worker has a bachelor's degree in human services and work experience with adults with serious mental illness.
    b. A paraprofessional mental health worker may have a bachelor's degree in a field other than human services or have a high school diploma and have work experience with adults with serious mental illness.
    c. These paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health aide), work experience (e.g., teaching), or life experience. These individuals have experience working with persons with serious mental illness and/or related training/work/life experience.
10. At least one full-time peer recovery specialist works in the program who: participates in all program planning processes; provides direct services in the community and peer counseling to motivate and encourage Members; provides essential expertise and consultation to the team; and serves as a link among individual Members, consumer groups, recovery-oriented services and supports in the community, and the program. The peer recovery specialist is a person with lived experience with mental health services for serious mental illness and demonstrates significant recovery. Certified Peer Specialists or equivalent training is required, as well as demonstrated competency in using recovery-oriented, peer-directed interventions.

11. One full-time staff designated as a housing resource specialist works in the program to assist Members in finding housing that is safe and affordable through establishing relationships with local housing authorities and housing programs.
12. The provider includes qualified clinicians and other staff able to meet the cultural and linguistic needs represented in the local community.
    a. The program has policies and procedures identifying how communication needs are assessed and ensuring translators are used for assessments, treatment planning and most interventions.
    b. Clinical staff persons with linguistic capacity are preferable to translators.
    c. When the provider must go outside the program, the team has access to qualified translators and translator services, experienced in behavioral health care, and a list is maintained of these qualified translators.
    d. Policies and procedures include how the need for a translator in an emergency will be handled.
13. The PACT program maintains the staffing levels and ratios as required in the program's contracts with the Department of Mental Health (DMH) and as needed to implement all performance specifications.
14. Each Member is assigned a primary care manager who ensures that services are relevant and coordinates and monitors the assessment, treatment planning, and service delivery activities carried out by the PACT team on behalf of the Member. The primary care manager has primary responsibility to write the treatment plan, provide individual supportive therapy, ensure immediate changes are made in the treatment plans as Member's needs change, and advocate for Member rights and preferences. The primary care manager is also the first responder when the Member is in crisis and is the primary support person and educator to the Member's family. The Member's individual treatment team shares these tasks with the primary care manager and is responsible for performing the tasks when the primary care manager is not available.
15. PACT's organizational structure emphasizes a team approach to assure the tight integration of clinical, rehabilitative, recovery, and support services. A key to this integrative process is the "team-within-a-team" concept. Through a "mini-team," each Member can work with a small core of staff whose overall abilities, specialty skills, and personality match the Member's interests and goals. This "mini team" interfaces with the larger PACT team and has responsibility for soliciting and blending in the perspective and analysis of all PACT team Members. Team communications are also essential to delivering an individualized mix of treatment, rehabilitation, and support services to each Member.
16. Each PACT team maintains a documented policy for supervision of all staff providing treatment, rehabilitation, and support services. The PACT team leader/program director and psychiatrist have responsibility for supervising and directing all PACT team staff activities, per the National Alliance on Mental Illness (NAMI) PACT Standards. Supervision provided to PACT team staff shall be documented in writing. This supervision and direction shall consist of:
    a. Individual, side-by-side sessions in which the supervisor accompanies an individual staff Member to meet with clients in regularly scheduled or crisis meetings;

b. Participation with team members in daily organizational staff meetings and regularly scheduled treatment planning meetings; and
c. Regular meetings with individual staff to review Members, assess performance, and give feedback.

17. As PACT is an evidence-based practice, staff are thoroughly knowledgeable about the philosophy, standards, and tools employed to make it effective. Further, PACT is an "umbrella" for staff to employ other evidence-based practices in working with Members. Staff are knowledgeable and competent in these practices, as applicable. The program documents initial staff orientation and at least annual training for all program staff in the PACT model.

Process Specifications

Assessment, Treatment Planning and Documentation

1. PACT team leaders/program directors participate in a referral meeting. Referrals are reviewed to ensure the Member meets PACT criteria and discuss any concerns. PACT teams are expected to take all referrals which meet criteria. Dates for admission are set at the referral meeting.
2. The team leader/program director and psychiatrist meet with the Member, within three (3) to four (4) business days from the referral meeting, to begin an initial intake and assessment and to complete a brief initial treatment plan. The initial assessment focuses on how the team can be helpful to the Member and support his/her immediate concerns and priorities. The initial assessment and brief treatment plan are completed by the Member's primary care manager. The Member's psychiatrist, primary care manager, and individual treatment team are assigned the Member by the program director within a week of admission.
3. A comprehensive assessment is completed within 30 days of the Member's admission. Its focus is to understand and respect the Members worldview and context of their lives. This includes the ways their psychiatric condition impacts their lives as a whole and how they want to be supported as they move through their own personal process of recovery.
4. Comprehensive assessments are completed by individuals on the team who have expertise in the life area being assessed. For example, the physical health component is completed by one of the team's RNs; the substance use disorder component is completed by staff on the team with substance use disorder treatment skills; an employment specialist on the team completes the education and employment component. The primary care manager is responsible for ensuring the completion of the comprehensive assessment by team members.
   a. The PACT team meets on or about day 30 after admission to compile and complete the comprehensive assessment. The team develops the 'integrated assessment summary' which pulls together all the assessment components and information from the Member about his/her experiences, current circumstances, and goals in several life areas:
      i. Psychiatric symptoms and their effects
      ii. Known trauma history
      iii. Strengths, skills, and periods of time identified by the Member as positive
      iv. Treatment history, including his/her experience of past treatment and his/her perception of its benefits/limitations
      v. Medical, dental, and other health needs

vi. Extent and effect of drugs and/or alcohol use
vii. Housing situation, conditions of daily living, housing preferences
viii. Rehabilitation, employment, and educational activities and interests
ix. Legal issues
x. Extent and effect of criminal justice involvement
xi. Level of family contact and support
xii. Social relationships and supports
xiii. Spiritual needs and interests
xiv. Recent life events

b. Finally, the Member and the PACT team come to agreement about the issues and priorities they will all work together to address. These issues are transformed into specific goals and outcomes the team will work with the Member to achieve.

5. A comprehensive treatment plan is completed within 30 days of an Member's admission to the program.
   a. The treatment plan states the Member's strengths, needs/problems, personal goals, and desired service outcomes; the specific interventions to be provided; names of persons providing the services; and estimated time and other resources needed to support the achievement of goals and outcomes.
   b. The following life needs are addressed in treatment plans: symptom self-management and education; getting and keeping affordable, quality housing; carrying out ADLs; finding and maintaining satisfying employment or other pursuits; enriching social and interpersonal relationships, including peer support; fulfilling spiritual needs; strengthening physical health; and creating crisis prevention strategies which address the Member's preferences in the event of a serious psychiatric emergency.
   c. The treatment plan includes psychosocial, educational and support services for the Member's family/significant others.
   d. All areas that the Member identifies as important to address are included in the treatment plan. If it is necessary to defer a particular issue, documentation substantiating the deferral is made.
6. The primary care manager is responsible for reviewing the service delivery goals and plan with the Member, at least every six (6) months and whenever there is a major decision point in the Member's course of treatment and rehabilitation.
7. The treatment plan is revised every six (6) months. The revised treatment plan is based on a mutual evaluation between Member and staff about accomplishment of desired goals and outcomes. A reassessment of current Member's needs and goals is then completed. The primary care manager prepares a written treatment plan review describing goals the Member has reached since the last treatment planning meeting and outlining his/her current strengths and areas of need. The Member, primary care manager, team leader/program director, and psychiatrist sign both the treatment plan review and the revised treatment plan.
8. The PACT team conducts treatment planning meetings, convened at regularly scheduled times.
   a. Treatment planning, led by each Member's "mini team," the team leader/program director and psychiatrist, represents a partnership between PACT teams, Members, and their families/significant others.

   b. Treatment planning meetings occur with sufficient frequency and duration to develop written individual treatment plans and to review and revise the treatment plans every six (6) months.
   c. Each Member participates in the plan in the way he/she prefers. If the Member chooses not to attend, the team insures Member input into the plan and approval of the plan.
9. The PACT team conducts daily organizational staff meetings under the supervision of the team leader/program director and the psychiatrist.
   a. These meetings are held five (5) days per week at regularly scheduled times, when the greatest number of staff is present.
   b. During these meetings, the team reviews the service contacts made the previous day and assesses their progress in helping Members meet desired outcomes. Acuity changes are noted and responded to that day with a specific plan incorporating the Member's own preferences and identified self-management practices. The goal is to work with Members to identify emotional changes early on so that life disrupting emergencies can be avoided.
   c. During these meetings a staff person, designated as "shift manager," coordinates a schedule of services that team Members need to provide that day and is the on-site contact to manage a response to unanticipated needs.
   d. The meeting also provides a formal opportunity to revise treatment plans as needed, plan for emergency/crisis situations, and add treatment and service contacts to the daily schedule per the revised or crisis treatment plans.

Disposition Planning and Documentation

1. Discharges from the PACT program occur when Members no longer meet medical necessity criteria. The program works to engage the Member, program staff, and DMH Site Office staff in mutual agreement of this determination and the termination of services. This generally occurs when a Member:
   a. Meets his/her goals in all major role areas (work, school, social, and self-care); has extended periods of community tenure; and has successful experiences in managing emotional crises and a non-mental health provider support system;
   b. Moves outside of the team's geographic area of responsibility. In such cases, the PACT team arranges for the transfer of mental health service responsibility to a provider in the geographic location to which the Member is moving (preferably another PACT team). The PACT team maintains contact with the Member until this service transfer is arranged and services are established; or
   c. Is in an institution (e.g., state hospital or prison) for an extended period, precluding the PACT team's ability to maintain a relationship with the Member.
   d. Progress has occurred that allows for treatment to continue at a less intensive level of care; or
   e. Requests discharge, despite the team's best effort to develop a treatment plan acceptable to the Member. This decision is reached jointly with the referring source.
2. The PACT team engages the Member in developing and implementing an aftercare plan, including but not limited to formal services and peer supports, as needed, when the Member meets the PACT discharge criteria established in his/her treatment plan.

3. The aftercare plan and all discharge planning activities are document in the Member's health record.

Service, Community, and Collateral Linkages

1. The PACT team develops linkages with a variety of peer support and self-help activities, which may include but not be limited to:
   a. Providing individual Members with resources that may foster their recovery process (e.g., symptom self-management strategies; self-help resources such as books, tapes, etc.);
   b. Fostering Member involvement in consumer-operated, recovery-oriented services and supports, including but not limited to Recovery Learning Communities, clubhouses, The Transformation Center, individual or group peer counseling and support; and warm lines;
   c. Facilitating Member's access to peer advocacy organizations; and
   d. Providing Member's family with information about family support and advocacy services and supports, including but not limited to NAMI.
2. With Member consent, the PACT team is responsible for:
   a. Coordinating and ensuring appropriate medical, dental, and vision services for each Member. The team establishes close working relationships with PCPs and specialty health care providers to support optimal health and assist in monitoring any medical conditions (e.g., diabetes, high cholesterol);
   b. Collaborating with the Member's PCP;
   c. Coordinating with psychiatric and general medical hospitals throughout a Member's inpatient stay. Team staff are present when the Member is admitted and visit the hospital daily for care coordination and discharge planning purposes;
   d. Maintaining relationships with detoxification and acute substance use disorder treatment services to coordinate care when PACT Members may need these services;
   e. Maintaining close working relationships with criminal justice representatives to support Members involved in the adult justice system (e.g., courts, probation officers, jails and correctional facilities, parole officers);
   f. Fostering close relationships with local housing organizations; and
   g. Creating a referral and resource guide for self-help groups and other community resources (e.g., legal aid organizations, food co-ops).
3. The provider develops an active working relationship with each of the local AMCIs who are high-volume referral sources for the provider. The provider holds regular meetings or has other contacts and communicates with the AMCI on clinical and administrative issues, as needed, to enhance the referral and admission process and continuity of care for Members. On a Member-specific basis, the provider collaborates with all AMCI providers upon admission to ensure the AMCIs evaluation and treatment recommendations are received and any existing crisis prevention plan and/or safety plan is obtained. In preparation for discharge, the provider develops or updates the Member's crisis prevention plan and/or safety plan and sends a copy to the Member's local AMCI provider with Member consent, or the provider contacts the AMCI provider and requests assistance with developing or updating a crisis prevention plan and/or safety plan.

Quality Management

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to SWH, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Members, including their families.
3. Clinical outcomes data must be made available to SWH upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.