

Intensive Case Management (ICM) Interim Program Standards
State of Alaska/DHSS/DBH

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I. Introduction

The following Intensive Case Management (ICM) Interim Program Standards guide ICM program implementation and define minimum requirements for an ICM team in the State of Alaska. ICM implementation in Alaska will emphasize intensive supported housing and community integration. ICM teams will focus and prioritize services to high utilizers of public resources (e.g., API, Psych ER, emergency responders, DOC), the chronic homeless, those precariously housed, and those living in, or at risk of living in unnecessarily restrictive and segregated environments (i.e., Olmstead class population).

ICM is a client-centered, recovery-oriented service delivery model that promotes community integration, independence and an improved quality of life through the provision and coordination of on-going direct services and supports. The priority population for ICM is adults experiencing a serious mental illness as defined in 7 AAC 70.990., who are in need of on-going and intensive supports to remain stable in the community.

ICM is a service delivery model in which case managers, working in teams, provide intensive outreach and engagement, coordinate with other service providers, and develop strong therapeutic relationships with recipients to help them get access to needed services, thereby enabling them to live in the least restrictive environment possible and increasing their adaptive capabilities. Interagency collaboration is essential to the success of the ICM model, so strong connections must be built across multiple systems to ensure continuity of care. The services directly provided, coordinated, and brokered with outside providers include supported housing services, crisis intervention, behavioral health treatment addressing both mental health and substance abuse issues, medical care, vocational and educational counseling, family and community integration, and any other treatment or supports requested by the recipient.

ICM is more than a brokerage function. It is an intensive service model that involves providing on-going support to help the recipient function in the least restrictive, most natural environment. Case managers work to build a trusting and productive relationship with the recipient and provide the support and resources the recipient needs to achieve goals, stability and an improved quality of life. The case manager maintains involvement, as recipient needs change and cross service settings. Service provision is flexible and managed in a manner that responds to the fluctuations in recipient needs over time. The intensive case management team composition must include staff with competencies specifically needed to assist with the special needs of the population.

ICM is a comprehensive service delivery system which involves the following components:

Outreach and engagement

- Assertive outreach and engagement to recipients in their place of choice
- Outreach and other service provision offered in the least intrusive manner possible
- Methods of outreach are adapted to meet varying needs
- Includes plans to manage a wait list

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Assessment and planning

- Comprehensive assessments that are continually updated as recipient needs change over time
- Highly individualized and integrated person-centered treatment plans
- Treatment plans identify other services and resources (beyond what the ICM team directly provides) to address the full range of a recipient's needs

Direct service provision and intervention

- Services provided by the ICM team are primarily community based (not office based)
- Comprehensive array of services offered, both directly provided and brokered
- Services are responsive and flexible to recipient's changing needs over time
- Staff to recipient ratio of no more than 1:15-20
- Frequency of services based on recipient need
- Services are flexible and available outside normal business hours
- Recipients have crisis plans
- Recipients are assigned a primary case manager to ensure consistency of service provision

Monitoring, evaluation, and follow up

- Recipients are actively involved in treatment planning and reviews
- Recipient satisfaction with services are regularly reviewed
- ICM teams conduct on-going evaluation of the program
- Teams engage in appropriate transition and discharge planning

Information, liaison, advocacy, consultation, and collaboration

- Strong partnerships and collaboration with community service providers
- Advocacy on behalf of recipient for services relevant to recipient needs

II. Definitions

Activities of Daily Living Services include approaches to support and build skills in a range of activities of daily living (ADLs), including but not limited to, performing household activities, carrying out personal hygiene and grooming tasks, money management, accessing and using transportation resources, and accessing services from a physician and dentist.

Clinical Supervision is a systematic process to review each recipient's clinical status and to ensure that the individualized services and interventions that the team members provide are planned with, purposeful for, effective, and satisfactory to the recipient. The team leader has the responsibility to provide clinical supervision which may include: 1) meeting as a group (separately from the team meeting) or individually to discuss specific clinical cases; 2) field mentoring (e.g., helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills); 3) reviewing and providing feedback on the specific tools (e.g.,

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the quality of assessments, treatment plans, progress notes); 4) didactic teaching and/or training; and 5) formal in-office individual supervision.

Comprehensive Assessment is the organized process of gathering and analyzing current and past information with each recipient and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the recipient and his/her recovery planning team in pursuing goals. The results of the information gathering and analysis are used to: 1) establish immediate and longer-term service needs with each recipient; 2) set goals and develop the initial person-centered treatment plan with each recipient; and 3) optimize benefit that can be derived from existing strengths and resources of the recipient and his/her family and/or natural support network in the community.

Initial Assessment and Person-centered Individualized Treatment Plan is the initial evaluation of: 1) the recipient's mental and functional status; 2) the effectiveness of past treatment; 3) the current treatment, and rehabilitation and support service needs, and 4) the range of individual strengths that can act as resources to the recipient in pursuing goals. The results of the information gathering and analysis are used to establish the initial treatment plan to achieve individual goals and support recovery. *Completed the day of admission*, the recipient's initial assessment and treatment plan guides services until the comprehensive assessment and a full person-centered treatment plan is completed.

Integrated Dual Disorders Treatment for Substance Abuse includes integrated and stage-wise assessment and treatment for recipients who have a co-occurring mental health and substance use disorder. This type of treatment is based on the short-term goal of risk reduction and the long-term goal of abstinence.

Peer Support Services include coaching and consultation services which serve to validate recipients' experiences, provide guidance and encouragement to recipients to take responsibility for and actively participate in their own recovery, and help recipients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce recipients' self-imposed stigma. Peer Support Services may be inclusive of Wellness Management Services, such as facilitation of Wellness Recovery Action Plans (WRAP) and Illness Management and Recovery (IMR) services.

Person-Centered Individualized Treatment Plan is the culmination of a continuing process involving each recipient, his/her family and/or natural supports in the community, other community partners providing services, and the ICM team, which individualizes service activity and intensity to meet the recipient's specific treatment, rehabilitation, and support needs. The written treatment plan documents the recipient's strengths, resources, self-determined goals, and the services necessary to help the recipient achieve them. The plan also

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delineates the roles and responsibilities of the team members who will work collaboratively with each recipient in carrying out the services. The person-centered individualized treatment plan must meet the standards outlined in this document, in addition to those outlined in 7 AAC 135.120.

Recipient is a person who has agreed to receive services and is receiving person-centered treatment, rehabilitation, and support services from the ICM team.

Recovery does not have a single agreed upon definition, “the overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.” (Mental Health: A Report of the Surgeon General, 1999, p 97)

Service Coordination is a process of organization and coordination within the ICM team and with other service providers, to carry out the range of treatment, rehabilitation, and support services each recipient expects to receive per his or her written person-centered treatment plan and that are respectful of the recipient’s wishes. Service coordination also includes coordination with community resources, community partners, including recipient self-help and advocacy organizations that promote recovery.

Stakeholder Advisory Groups support and guide ICM team implementation and operation and will serve as a steering committee. ICM teams will include leadership representation from the local homeless coalition, state government, local interested community councils, representatives from the business community, and consumer and emergency response provider groups. This steering committee will allow for community input into program responsiveness and feedback on neighborhood impact of the program.

Supported Education provides the opportunities, resources, and supports to recipients so that they may gain admission to and succeed in the pursuit of post-secondary education, including high school, GED, and vocational school.

Team Meeting is a staff meeting, held *at minimum weekly* and at regularly scheduled times, under the direction of the team leader (or designee) to: 1) briefly review the service contacts which have occurred and the status of all program recipients; 2) review the service contacts which are scheduled to be completed and revise as needed; 3) when not already assigned within the weekly recipient schedule, assign staff to carry out service activities; and 4) plan for emergency and crisis situations as needed.

Tenancy Support Services include pre-tenancy supports, move-in supports, and on-going housing stability services with the goal of recipients achieving long term tenancy.

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Treatment Plan Review is a thorough, written summary describing the recipient's and the treatment team's evaluation of the recipient's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan.

Treatment Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader. The purpose of these meetings is for the ICM staff, community service providers, and the recipient and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the recipient's life, his/her experience with mental illness or substance abuse, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each recipient and his/her goals and aspirations and for each recipient to become familiar with each staff person; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each.

Vocational Services include work-related services to help recipients value and understand the implications of, as well as find and maintain meaningful competitive employment in, community-based job sites. Vocational services also include job development and coordination with employers, as well as follow-along job supports provided to the employer (at the recipient's request) and recipient.

Weekly Recipient Schedule is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given recipient's person-centered treatment plan. The team shall maintain an up-to-date weekly recipient schedule for each recipient per the person-centered treatment plan.

Wellness Management and Recovery Services are a combination of psychosocial approaches to working with the recipient to build and apply skills related to his or her recovery, including development of recovery strategies, psychoeducation about mental illness and the stress-vulnerability model, building social support, reducing relapses, using medication effectively, coping with stress, symptom management, and getting needs met within the mental health system and community. Examples of such services include Wellness Recovery Action Planning (WRAP) and Illness Management and Recovery (IMR).

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III. Provider Requirements

A. Qualifications

The ICM team is administered by a Community Behavioral Health Services Provider that meets all of the following requirements:

1. Meets the qualifications of Community Behavioral Health Services Provider receiving money from the Department as defined in 7 AAC 70.100.;
2. Has a current Department Approval to provide behavioral health services, or be eligible for a Department Approval under 7 AAC 70.030.;
3. Demonstrates adherence to all applicable regulations and grant requirements by remaining in good standing with integrated Departmental Site Reviews, Grant Agreements, and national accreditation;
4. Is established as a legally constituted entity capable of meeting all of the requirements of the Department Approval, Medicaid Regulations, Medicaid Enrollment Agreement, and ICM Interim Program Standards; and
5. Shall comply with all applicable federal and state requirements. This includes but is not limited to State of Alaska Department of Health and Social Services (DHSS) statutes, rules, policies, and regulations; Medicaid Regulations; and other published instruction.

B. Medicaid Enrollment

1. ICM team provider organizations must be an enrolled State of Alaska Medicaid provider.
2. Provider organization is responsible for ensuring that all services are medically necessary and all services are in full compliance with all applicable Medicaid service regulations, including but not limited to Chapters 70, 105, and 135.

The provider organization is responsible for all ICM service delivery, and understands that not all ICM required activities are eligible for Medicaid billing. It is the provider's responsibility to adhere to all applicable Medicaid regulations, while simultaneously adhering to ICM program standards.

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IV. Admission and Discharge Criteria

A. Admission Criteria

Recipients must meet the following three admission criteria:

1. A diagnosable mental, emotional, or behavioral disorder of sufficient duration to meet diagnostic criteria specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, that has resulted in functional impairments that substantially interferes with or limits one or more major life activities. Persons who have not been able to remain abstinent from drugs or alcohol will not be excluded from ICM services.
2. Significant functional impairments as demonstrated by at least one of the following conditions:
 - a. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
 - b. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
 - c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
3. Continuous high-service needs as demonstrated by at least one of the following:
 - a. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
 - b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
 - c. Co-occurring substance use disorder of significant duration (e.g., greater than six months).
 - d. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
 - e. Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at imminent risk of becoming homeless.

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- f. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
- g. Difficulty effectively utilizing or benefiting from traditional office-based outpatient services or other less-intensive community-based programs (e.g., recipient fails to progress, drops out of service).

4. Documentation of admission shall include:

- a. The reasons for admission as stated by both the recipient and the ICM team.
- b. Documentation of how recipient meets admission criteria.

Note: Specific grant funded programs may have additional admission requirements.

B. Discharge Criteria

1. Discharges from the ICM team occur when recipients and ICM staff mutually agree to the termination of services. This shall occur when recipients:
 - a. Have successfully reached individually established goals for discharge and when the recipient and program staff mutually agrees to graduation from ICM services.
 - b. Move outside the geographic area of ICM's responsibility. In such cases, the ICM team shall arrange for transfer of behavioral health service responsibility to an ICM program or another provider wherever the recipient is moving. The ICM team shall maintain contact with the recipient until this service transfer is completed.
 - c. Demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without requiring ongoing assistance from the program for six to nine months without significant relapse when services are withdrawn.
 - d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable person-centered treatment plan with the recipient.
2. In addition to the discharge criteria listed above based on mutual agreement between the recipient and ICM staff, a recipient discharge may also be facilitated due to any one of the following circumstances:
 - a. Death.
 - b. Inability to locate the recipient for a prolonged period of time.
 - c. Long-term incarceration.
 - d. Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the ICM team that the

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recipient will not be appropriate for discharge for a prolonged period of time.

3. If the recipient is accessible at the time of discharge the team shall ensure recipient participation in all discharge activities, as evidenced by documentation as described below:
 - a. The reasons for discharge as stated by both the recipient and the ICM team.
 - b. The recipient's bio-psychosocial status at discharge.
 - c. A written final evaluation summary of the recipient's progress toward the goals set forth in the person-centered treatment plan.
 - d. A plan developed in conjunction with the recipient for follow-up treatment after discharge.
 - e. The signature of the recipient, the recipient's case manager, and the team leader.
4. When clinically necessary, the team will make provisions for expedited re-entry of discharged recipients as rapidly as possible and will prioritize them on the admission and/or waiting list.

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

V. Service Intensity and Capacity

A. Staff-to-Recipient Ratio

Each ICM team shall have the organizational capacity to provide a minimum staff-to-recipient ratio of at least one full-time equivalent (FTE) staff person for every 15-20 recipients, not including the program assistant.

B. Staff Coverage

Each ICM team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services to recipients in the community, offered at times that meet the diverse needs of this vulnerable population.

C. Frequency of Recipient Contact

1. The ICM team shall have the capacity to provide multiple contacts per week with recipients experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, and should depend on recipient need and be a mutually agreed upon plan between recipient and program staff.

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2. The ICM team shall have the capacity to rapidly increase service intensity to a recipient when his or her status requires it or a recipient requests it.
3. The ICM team shall collect data regarding the frequency of recipient contacts and be reviewed as part of the program's performance improvement plan.
4. The ICM team shall deliver services based on the individual needs of the recipient. Service delivery should demonstrate flexibility and is expected to change over time, with the frequency and intensity of services determined by recipient need.

Policy and Procedure Requirements: The ICM team shall maintain written service intensity and capacity policies and procedures.

VI. Staff Requirements

A. Qualifications

The ICM team shall have among its staff, persons with sufficient individual competence and professional qualifications and experience to provide the services described in the ICM Interim Program Standards.

B. Team Size

A full size ICM team that services 50-60 recipients shall employ at *minimum*, 2.5-3 FTE case managers, 1 FTE team leader and .5 FTE program/administrative assistant.

C. Required Staff

The following provides a description of and qualifications for required staff on all ICM teams.

Team Leader: A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing Clinician on the ICM team. The team leader would preferably be a licensed Clinician, but at minimum must meet the criteria of a Mental Health Professional Clinician as defined in 7 AAC 70.990.

Case Managers: Case Managers are responsible for providing assertive outreach and engagement, developing strong therapeutic alliances with recipients, providing behavioral health rehabilitation, crisis response/intervention, and service coordination. They must, at *minimum*, meet the criteria of a Behavioral Health Clinical Associate or a Mental Health Professional Clinician as defined in 7 AAC 70.990.

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Housing Specialist: One or more team members with at least one year of training and experience in providing tenancy support services shall be designated the role of housing specialist. This does not have to be an *additional* position on the team, but there does need to be at least one person identified on the team that has the training and experience to assume this role.

Program/Administrative Assistant: The program/administrative assistant is responsible for organizing, coordinating, and monitoring all nonclinical operations of ICM, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for recipient and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and recipients.

Peer Specialist (optional): A person who is or has been a recipient of mental health services for a serious mental illness holds this position. Because of their life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote recipient self-determination and decision-making. Peer specialists validate recipients' experiences, guide and encourage recipients to take responsibility for and actively participate in their own recovery, as well as provide services to help recipients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce recipients' self-imposed stigma. Peer specialists also provide essential expertise and consultation to the entire team to promote an organizational culture in which each recipient's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

Policy and Procedure Requirements: The ICM teams shall: 1) maintain written personnel policies and procedures for hiring; 2) establish core staff competencies, orientation, and training; and 3) maintain personnel files for each team member containing the job application, copies of credentials or licenses, position description, annual performance appraisals, and individual orientation and training plan.

VII. Program Organization and Communication

A. Hours of Operation and Staff Coverage

The ICM team shall design hours of operation and staff coverage to be available to provide treatment, rehabilitation, crisis intervention, and support activities to recipients in the community, at times that meet the diverse needs of this vulnerable population. At minimum the ICM team shall provide:

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1. Regular operating hours, with flexibility and some coverage during non-traditional business hours (i.e., offering some operating hours outside the standard Monday-Friday, 8-5)
2. On-call crisis response to recipients during regular operating hours. The ICM team should be available to respond to recipients by telephone or by going out to see recipients who need face-to-face contact.
3. On-call crisis response to landlords to resolve housing issues, provide support and resolution of household emergencies, and to ensure long term tenancy for recipients.
4. Coordination with community service providers to ensure recipients have access to appropriate crisis resources, to include 24/7 on-call response/consultation with the local emergency room or other emergency service providers for coordination of care.

B. Place of Treatment

Ideally and at the discretion of the recipient, service contacts will occur in the recipient's community or home in order to better understand their living environment. Each team shall set a goal of providing 75 percent of service contacts in the community in non-office-based or non-facility-based settings. Data regarding the percentage of recipient contacts in the community will be collected and reviewed to verify that goals are being met as part of the program's performance improvement plan.

C. Staff Communication and Planning

1. The ICM team shall conduct **team meetings**, *at minimum weekly* and at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted for the purpose of assessing the progress and status of all recipients served in the program. These meetings are held in addition to the regularly scheduled treatment planning meetings.
 - a. The ICM team, under the direction of the team leader, shall maintain a **weekly recipient schedule** for each recipient. The weekly recipient schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the recipient's person-centered treatment plan. The team will maintain a central file of all weekly recipient schedules.
 - b. During the team meeting, the ICM team shall discuss and schedule any additional contacts based on emerging recipient needs and crises, as well as proactive contacts to prevent future crises.

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2. The ICM team shall conduct **person-centered treatment planning meetings** under the supervision of the team leader. These treatment planning meetings shall:
 - a. Convene at regularly scheduled times per a written or computerized schedule maintained by the team leader.
 - b. Occur and be scheduled when the recipient and the majority of the team members, including community service providers, can attend. These meetings may also include the recipient's family and/or natural supports, if desired and available.
 - c. Require individual staff members to present and systematically review and integrate recipient information into a holistic analysis and work with the recipient and the team to establish priorities for services.
 - d. Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each recipient and their goals and aspirations and for each recipient to become familiar with staff; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; to participate with the recipient and the team in the development and the revision of the person-centered treatment plan; and to fully understand the treatment plan rationale in order to carry out the plan with each recipient at least every 90-135 days.
- D. Staff Supervision**
- Each ICM team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:
1. Individual, side-by-side field mentoring sessions in which the supervisor accompanies an individual staff member to meet with recipients in regularly scheduled or crisis meetings to assess their performance, give feedback, and model alternative treatment approaches;
 2. Regular individual or group meetings with staff to review their work with recipients, assess clinical performance, and give feedback;
 3. Regular reviews, critiques, and feedback on staff documentation (i.e., progress notes, assessments, treatment plans, treatment plan reviews);
 4. Didactic teaching and/or training; and

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5. Written documentation of all clinical supervision provided to ICM team staff.

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

VIII. Assessment and Person-Centered Treatment Planning

A. Initial Assessment and Treatment Plan

An initial, brief assessment and treatment plan shall be done the day of the recipient's admission to ICM by the team leader. Other appropriately qualified designated team members may also conduct the initial assessment/treatment plan, with review and approval by the team leader.

B. Comprehensive Assessment

The assessment is based upon all available information, including that from recipient interview/self-report, family and/or natural supports, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within four weeks of a recipient's admission according to the following requirements:

1. In collaboration with the recipient, the comprehensive assessment shall include an evaluation of the following areas:
 - a. *Psychiatric History, Mental Status, and Diagnosis*
 - b. *Physical Health*
 - c. *Use of Drugs and Alcohol*
 - d. *Housing:* Included in this area is the assessment of the recipient's current housing situation, including exploration of their needs and preferences related to housing. The assessment should focus on current barriers to accessing and maintaining good quality, safe, and affordable housing.
 - e. *Education and Employment:* Included in this area is the assessment of community inclusion and integration as it relates to education and employment. The assessment emphasizes the recipient's desire and goals related to education and employment rather than the team member's determination of readiness. Information gathered during ongoing work-based assessments is not to determine employability, but to determine type of job and supports required to help the recipient succeed in work and education including the type of environments that will promote recovery and positive work/education experiences and education and job accommodations to support the recipient's success. A vocational profile should be updated with each new job and education experience.

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- f. ***Social Development and Functioning:*** Included in this area is the assessment of the individual's social and interpersonal inclusion and integration within the community.
 - g. ***Activities of Daily Living (ADL)***
 - h. ***Family Structure and Relationships***
 - i. ***Strengths and Resources:*** These may include: skills, talents, personal virtues and traits, interpersonal skills, interpersonal and environmental resources, cultural knowledge and lore, family stories and narratives, knowledge gained from struggling with adversity, knowledge gained from occupational and parental roles, spirituality and faith, and hopes, dreams, goals, and aspirations.
2. The comprehensive assessment is completed within one month of the recipient's admission to the program. After the assessment formulation is complete, the team will solicit feedback from the recipient and obtain his/her signature indicating participation in the assessment process. A copy of the signed assessment shall be made available to the recipient.
 3. The comprehensive assessment must meet the standards outlined in this document, in addition to those outlined in 7 AAC 135.110.

C. **Person-Centered Treatment Planning**

Person-centered treatment plans will be developed through the following treatment planning process **within 30 days** of a recipient's admission to the team:

1. ICM team staff shall meet at regularly scheduled times for treatment planning meetings. At each treatment planning meeting the following staff should attend: the team leader, the primary case manager, any community partners providing brokered treatment services including a psychiatric prescriber, and all other ICM team members who are assigned to provide treatment, rehabilitation, and support with the recipient. ICM staff shall make every effort to ensure that the recipient and his/her family and/or natural supports (if desired by the recipient) are supported and in attendance at the treatment planning meeting.
2. The person-centered treatment plan shall be developed in collaboration with the recipient and his/her preferred natural supporters, and/or guardian, if any, when feasible and appropriate. The recipient's participation in the development of the treatment plan shall be documented. The ICM team shall evaluate together with each recipient their needs, strengths, and preferences and develop together with each recipient a person-centered treatment plan. The treatment plan shall identify individual service needs; strengths and capacities; set specific and measurable long- and short-term goals for each service need/issue; establish the specific approaches and interventions necessary for the recipient to meet his/her

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goals, improve his/her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life). The recipient's own words are reflected in the treatment plan.

3. The primary case manager is responsible to provide the necessary support to ensure the recipient is actively involved in the development of treatment (recovery) and service goals and participation in the treatment plan meetings. This may include offering of peer-based coaching and/or skills training around his/her role in developing their own person-centered treatment plan. With the permission of the recipient, ICM team staff shall also involve pertinent agencies and members of the recipient's social network in the formulation of treatment plans.
4. Each recipient's treatment plan shall identify specific measurable recipient goals, followed by recipient strengths and potential barriers to each goal. The treatment plan must then clearly specify the approaches and interventions necessary for the recipient to achieve the individual goals (i.e., recovery) and identify who will carry out the approaches and interventions.
5. The following key areas should be addressed in every recipient's person-centered treatment plan unless they are explored and designated as "not of current interest" by the recipient: psychiatric illness or symptom reduction; housing; ADL; daily structure and employment; family and social relationships; physical health; and other life areas, goals and aspirations as identified by the recipient (e.g., community activities, empowerment, decision-making).
6. The primary case manager (under the direction of the team leader) shall prepare a summary (i.e., treatment plan review) which thoroughly describes in writing the recipient's and the team's evaluation of his/ her progress/goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last treatment plan. The plan and review will be signed or acknowledged by the recipient, the primary case manager, the team leader, and any community partners providing brokered treatment services including a psychiatric prescriber. A copy of the signed person-centered plan is made available to the recipient.
7. The person-centered individualized treatment plan must meet the standards outlined in this document, in addition to those outlined in 7 AAC 135.120.

Policy and Procedure Requirement: The ICM team shall maintain written assessment and treatment planning policies and procedures incorporating the requirements outlined in this section.

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VIII. Required Core ICM Services

The ICM team shall have the capacity to provide comprehensive treatment, rehabilitation, and support services through both direct service provision and through coordination and brokering with community partners. Services shall minimally include the following:

A. Service Coordination

Each recipient will be assigned a primary case manager who coordinates and monitors the activities of the recipient's treatment. The case manager is responsible for providing support, to offer options and choices in the treatment plan, to ensure that immediate changes are made as the recipient's needs change, and to advocate for the recipient's wishes, rights, and preferences. The primary case manager may be the first staff person called on when the recipient is in crisis. Members of the ICM team share these tasks with the primary case manager and are responsible to perform the tasks when the primary case manager is not working. Service coordination also includes coordination with community resources, community partners providing other services, and recipient self-help and advocacy organizations that promote recovery.

B. Crisis Assessment and Intervention

1. Each ICM recipient will have an individualized, strengths based crisis plan that will assist the ICM team when responding to a crisis. As with the treatment planning process, the recipient will take the lead role in developing the crisis plan.
2. The ICM team will provide on-call crisis response to recipients during regular operating hours. The ICM team should be available to respond to recipients by telephone or by going out to see recipients who need face-to-face contact.
3. The ICM team should provide on-call crisis response to landlords to resolve housing issues, provide support and resolution of household emergencies, and to ensure long term tenancy for recipients.
4. There should be coordination with community service providers to ensure recipients have access to appropriate crisis resources, to include on-call response/consultation with the local emergency room or other emergency providers for coordination of care. Whenever possible, a representative from the ICM team will be present to support the ICM recipient when external crisis responders are involved with the recipient.

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C. Assertive Outreach and Engagement

1. The ICM team will engage in active outreach (face-to-face interaction) with people in the streets, shelters, under bridges, and in other non-traditional settings. Active outreach will include identifying individuals in need, screening, developing rapport, offering support while assisting with immediate and basic needs, and referral to appropriate resources.
2. The ICM team will use a variety of techniques to engage recipients, including the use of collaborative and motivational interventions to engage recipients and promote recipients' development of intrinsic motivation to receive services from the ICM team.
3. In addition to being proficient in a range of engagement interventions, the team will have a thoughtful process for evaluating and measuring the effectiveness of techniques and modifying approaches when necessary.

D. Assessment and Service Planning

Assessment and Service planning shall include but not be limited to the following:

1. Update and revise, in partnership with the recipient, an individualized, comprehensive assessment.
2. Assess transition readiness on an ongoing basis using standardized tools.
3. Update and revise, in partnership with the recipient, an individualized, comprehensive, culturally sensitive, goal-oriented person-centered treatment plan.
4. Identify individualized strengths, resources, preferences, needs, and goals, and include identified strengths in the treatment plan goals and action steps.
5. Create specific and clinically thoughtful interventions to be delivered by the team, which are then cross-walked to a recipient weekly/monthly schedule used to guide day-to-day team planning.
6. Identify risk factors for harm to self or others.
7. Monitor response to treatment, rehabilitation, and support services.
8. Develop person-centered, functional crisis plans.

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E. Empirically Supported Interventions and Psychotherapy

1. Clinicians should provide individual and/or group psychotherapy as specified in the recipient's treatment plan.
2. Clinicians should use empirically supported techniques to address specific psychological and behavioral problems (e.g., anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms).

F. Wellness Self-Management and Relapse Prevention

Wellness Self-Management and Relapse Prevention services shall include but not be limited to the following:

1. Defining and identifying the recipient's recovery goals within the recipient's frame of reference.
2. Developing strategies for implementing and maintaining the identified recovery goals.
3. Education about mental illness, treatment, and recovery.
4. Teaching skills for coping with specific symptoms and stress management.
5. Facilitating the development of a personal crisis management plan, including suicide prevention or psychiatric advance directive.
6. Developing a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies.
7. Delivery of wellness management interventions via group and individual work such as Wellness Recovery Action Plans (WRAP) or Illness/Wellness Management and Recovery (IMR/WMR).

G. Medication Support

Medication Support services shall include but not be limited to the following:

1. Prescription, administration, and ordering of medication by appropriate medical staff.
2. Assisting recipients in accessing medications.
3. Monitoring medication response and side effects.

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4. Educating recipients about medications.
5. Helping recipients develop the ability to take medications with greater independence.

H. Integrated Dual Disorders Treatment for Substance Abuse

Services will include but not be limited to the following:

1. Providing support that is non-confrontational and that promotes harm reduction or abstinence, depending on the recipient's stage of change readiness.
2. Assessing stages of change readiness and related stage of treatment.
3. Providing outreach and engagement to those in a pre-contemplation or contemplation stage of change readiness.
4. Using motivational interviewing for those in contemplation and preparation phase of change readiness.
5. Providing active substance abuse counseling and relapse prevention, using cognitive-behavioral interventions, for those in late stages of change readiness.
6. Educating on substance abuse and interaction with mental illness.
7. Providing individual and group modalities for dual disorders treatment.

I. Tenancy Support Services (Housing)

Tenancy support services should be consistent with an evidenced-based Supportive Housing Model and include but not be limited to the following:

1. Pre-Tenancy Supports
 - a. Assisting recipients to define housing needs and preferences
 - b. Assessment of barriers to accessing and maintaining housing
 - c. Assisting recipients in finding good quality, safe, and affordable housing that follows the recipient's preferences in level of independence and location (e.g., housing search, finding a roommate, rental application, assistance with rental interview, facilitation of housing unit inspection)
 - d. Assisting with locating housing options with a focus on integrated independent settings

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- e. Applying for housing subsidies and housing programs
2. Move-In Supports
 - a. Assisting recipients with household set up (e.g., procuring necessities, such as bedding, kitchen supplies, household furniture, telephone, and assistance with security deposit)
 - b. Physically assisting with move-in or re-location
 - c. Facilitation of meeting property manager, neighbors, and other important contacts
 - d. Assisting the recipient in negotiating and understanding the terms of the lease and paying rent and utilities
3. On-going Housing Stability Services
 - a. Providing necessary supports and skills training to achieve long term tenancy (e.g., training on tenant expectations and skills (Ready to Rent), maintaining regular contact with and developing amicable relationship with landlord, serving as the ready contact person for landlords in order to avoid and resolve housing issues)
 - b. Providing tenancy support and advocacy for the recipient's tenancy rights at the individual's home at least monthly
 - c. Assisting recipient with community and neighborhood integration
 - d. Providing tenant rights education and periodic meetings with property manager to proactively address tenancy issues
 - e. Emergent visits to recipient for support/resolution of household emergencies (eviction prevention/mediation activities)
 - f. Providing tenancy support services to recipients transitioning to the community from institution or congregate settings

J. Education Services

Supported education related services are for ICM recipients whose high school, college or vocational education was interrupted or prevented. Services provide support to enrolling and participating in educational activities.

1. Strengths-based assessment of educational interests, abilities and history.
2. Pre-admission counseling to determine which school and/or type of educational opportunities may be available.
3. If indicated, referral to GED classes and testing.
4. Assistance with completion of applications and financial aid forms.
5. Help with registration.

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6. Orientation to campus buildings and school services.
7. Assessment of learning style and study skills.
8. Early identification and intervention with academic difficulties.
9. Linking with academic supports such as tutoring and learning resources.
10. Assistance with time management and schoolwork deadlines.
11. Supportive counseling.
12. Information regarding disclosing mental illness.
13. Advocating with faculty for reasonable accommodations.

K. Vocational Services

Vocational Services will be in alignment with evidenced-based Supported Employment models and will include but not be limited to the following:

1. Encouraging, motivating, and assistance with identifying and developing interests and skills.
2. Direct assistance with job development that includes locating preferred jobs, assisting with the application process, and involvement with employers.
3. Providing ongoing supports, such as job coaching.
4. Developing and strengthening relationships with local employers and other vocational support agencies.
5. Educating employers about available vocational supports and working with individuals with disabilities, such as serious mental illness.
6. Surveying local employers to identify various work settings and job roles.
7. Exploring and proposing job carving options with employers (e.g., breaking down a job role into multiple job roles with a more limited list of tasks and responsibilities, and full-time equivalent requirements).
8. Finding, enrolling, and supportive participation in school/training programs.
9. Providing benefits counseling and linkage to SSA work incentives.

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L. Psychiatric Rehabilitation and Assistance with Activities of Daily Living

These include services to support activities of daily living in community-based settings, include individualized assessment, problem solving, skills training/practice, sufficient side-by-side assistance and support, modeling, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist recipients to gain or use the skills required to:

1. Perform household activities, including household maintenance and cleaning, cooking, grocery shopping, and laundry.
2. Carry out personal hygiene and grooming tasks, as needed.
3. Develop or improve money-management skills.
4. Maintain safety in home and community.
5. Dress appropriately for the weather, including the purchase and care of appropriate clothing.
6. Develop healthy, appropriate, and satisfying social relationships.
7. Use available transportation.
8. Have and effectively use a personal physician and dentist.
9. Access legal advocacy and representation, if needed.

M. Social and Community Integration Skills Training

Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skill training. Specific interventions include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to help structure recipients' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

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

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2. Develop social skills, increase social experiences, and where appropriate, develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

N. Family Life and Social Relationships

Services provided under this category include:

1. Restoration and strengthening the recipient's unique social and family relationships.
2. Providing psycho-educational services (e.g., providing accurate information on mental illness and treatment to families and facilitating communication skills and problem solving).
3. Coordinating with child welfare and family agencies.
4. Support in carrying out parent role.
5. Teaching coping skills to families in order to support recipient's recovery.
6. Enlisting family support in recovery of the recipient.
7. Facilitating the recipient's natural supports through access to local support networks and trainings, such as NAMI's Family-to-Family.
8. Helping recipients expand network of natural supports.

O. Health

Services provided under this category include:

1. Educating recipients to prevent health problems.
2. Providing and coordinating medical screening and follow up.

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3. Scheduling routine and acute medical and dental care visits, and assisting recipient in attending these visits.
4. Sex education and counseling.
5. Health and nutrition counseling.

P. Money Management and Entitlements

Services provided under this category include:

1. Assisting recipient in gathering documents and completing entitlement and other benefit applications.
2. Accompanying recipients to entitlement offices.
3. Assisting with re-determination of benefits.
4. Providing financial crisis management.
5. Teaching budgeting skills and asset development.
6. Teaching skills in managing food stamps.
7. Assisting with representative payee, if needed.

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

IX. Recipient Medical Record

- A. The ICM team shall maintain a treatment record for each recipient.
- B. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the recipient's care and treatment.
- C. The record shall accurately document assessments, treatment plans, and the nature and extent of services provided, such as a person unfamiliar with the ICM team can easily identify the recipient's treatment needs and services received.
- D. The team leader and the program assistant shall be responsible for the maintenance and security of the recipient treatment records.

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- E. The recipient records are located at ICM team headquarters and, for confidentiality and security, are to be kept in a locked file.
- F. For purposes of confidentiality, disclosure of treatment records by the ICM team is subject to all the provisions of applicable state and federal laws.
- G. Recipients shall be informed by staff of their right to review their record and the process involved to request to do so.
- H. Each recipient's clinical record shall be available for review and may be copied by authorized personnel.

Policy and Procedure Requirement: The ICM team shall maintain written medical records management policies and procedures.

X. Recipient Rights and Grievance Procedures

- A. ICM teams shall be knowledgeable about and familiar with recipient rights including the rights to:
 - 1. Confidentiality
 - 2. Informed consent to medication and treatment
 - 3. Treatment with respect and dignity
 - 4. Prompt, adequate, and appropriate treatment
 - 5. Treatment which is under the least restrictive conditions
 - 6. Nondiscrimination
 - 7. Voice or file grievances or complaints
- B. ICM teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce recipient rights. These include:

Grievance or complaint procedures under:

- 1. Alaska Administrative Code and Statute
 - 2. Medicaid
 - 3. Americans with Disabilities Act
 - 4. Protection and Advocacy for Mentally Ill Individuals
 - 5. Local and State Tenant Rights Laws
- C. ICM teams shall provide recipients with information regarding their rights and grievance procedures.

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- D. ICM teams shall be prepared and provide recipients with appropriate information and referral to the Protection and Advocacy agency and other advocacy groups.

Policy and Procedure Requirement: The ICM team shall maintain recipient rights policies and procedures.

XI. Culturally and Linguistically Appropriate Services (CLAS) United States. Dept. of Health and Human Services. Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. [Rockville, MD]: U.S. Dept. of Health and Human Services, 2001.

- A. ICM teams should ensure that recipients receive from all staff members, effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices. ICM teams will also make every attempt to ensure that recipients receive services in their preferred language and will make arrangements for interpreter services, if available.
- B. ICM teams should implement strategies to recruit, retain, and promote a diverse staff that are representative of the demographic characteristics of the service area.
- C. ICM teams should ensure that staff at all levels and across all disciplines receives ongoing education and training in culturally and linguistically appropriate service delivery.
- D. ICM teams must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each recipient with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.
- E. ICM teams must provide to recipients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- F. ICM teams must assure the competence of language assistance provided to limited English-proficient recipients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except by request of the recipient).
- G. ICM teams must make available easily understood recipient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- H. ICM teams should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management

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- accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- I. ICM teams should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, recipient satisfaction assessments and outcome-based evaluations.
 - J. ICM should ensure that data on the individual recipient's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and be periodically updated.
 - K. ICM teams should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and recipient involvement in designing and implementing CLAS-related activities.
 - L. ICM should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by recipient.
 - M. ICM is encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Policy and Procedure Requirement: The ICM team shall maintain written Culturally and Linguistically Appropriate Services (CLAS) policies and procedures incorporating the requirements outlined in this section.

XII. Performance Improvement and Program Evaluation

The ICM team shall have a performance improvement and program evaluation plan, which shall include the following:

- A. A statement of the program's objectives. The objectives shall relate directly to the program's recipients or target population.
- B. Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
- C. Methods for documenting achievements related to the program's stated objectives.

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- D. Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
- E. In addition to the performance improvement and program evaluation plan, the ICM team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

Policy and Procedure Requirement: The ICM team shall maintain performance improvement and program evaluation policies and procedures.

XIII. Stakeholder Advisory Groups

- A. The ICM team shall have a stakeholder advisory group to support and guide ICM team implementation and operation. The stakeholder advisory group will serve as a steering committee that will include representation from the local homeless coalition, local government, local interested community councils, representatives from the business community, and consumer and emergency response provider groups. This steering committee will allow for community input into program responsiveness and feedback on neighborhood impact of the program. The Stakeholder Advisory Group shall not have access to individually-identifiable recipient information without written recipient consent. The stakeholder advisory group shall:
 1. Promote quality ICM programs
 2. Problem-solve and advocate to reduce system barriers to ICM implementation
 3. Promote and ensure recipients' empowerment and recovery values in ICM programs.

Policy and Procedure Requirement: The ICM team shall maintain written stakeholder advisory group policies and procedures, incorporating the requirements outlined in this section.

XIV. Waiver of Provisions

The ICM team may request of the ICM certification entity a waiver of any requirement of this standard that would not diminish the effectiveness of the ICM model, violate the purposes of the program, or adversely affect recipients' health and welfare. Waivers cannot be granted which are inconsistent with recipient rights or federal, state, or local laws and regulations.

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Summary of Policy and Procedure Requirements

- Admission and Discharge
- Service Intensity and Capacity
- Staff Requirements
- Program Organization and Communication
- Assessment and Person-Centered Treatment Planning
- Required Core ICM Services
- Recipient Medical Record
- Recipient Rights and Grievance Procedures
- Culturally and Linguistically Appropriate Services
- Performance Improvement and Program Evaluation
- Stakeholder Advisory Groups