

Assertive Community Treatment - ACLA

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Recent review date: 9/2022

Next review date: 1/2024

Policy contains: Assertive Community Treatment; bipolar disorder; major depressive disorder; Program of Assertive Community Treatment; schizophrenia; substance use disorder.

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Coverage policy

Assertive Community Treatment is clinically proven and, therefore, medically necessary for members who have a severe and persistent mental illness that seriously impairs their functioning in the community, when provided in accordance with Louisiana Department of Health behavioral health (2021) criteria and the following criteria for admission, exception, continued review, and discharge of services:

Admission criteria – must have one of the following (National Alliance on Mental Illness Minnesota, 2017; Substance Abuse and Mental Health Services Administration, 2008):

- Age 18 years or older.
- A *Diagnostic and Statistical Manual of Mental Disorders — Fifth Edition* diagnosis consistent with a serious and persistent mental illness, which includes schizophrenia, bipolar disorder, major depressive disorder, and other psychotic disorders.
- Substance use disorders, developmental disorders, organic brain syndromes, or social conditions are excluded, unless they occur with a diagnosable serious mental illness.
- At least one of the following service needs:
 - Two or more acute psychiatric hospitalizations and/or four or more emergency room visits in the last six months.
 - Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life.
 - Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.

- Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment).
- One or more incarcerations in the past year related to mental illness or substance use (Forensic Assertive Community Treatment).
- Psychiatric and judicial determination that Forensic Assertive Community Treatment services are necessary to facilitate release from a forensic hospitalization or pretrial to a lesser restrictive setting.
- Recommendations by probation and parole, or a judge with a Forensic Assertive Community Treatment screening interview, indicating services are necessary to prevent probation/parole violation.
- Must have one of the following:
 - Inability to participate or remain engaged or respond to traditional community-based services.
 - Inability to meet basic survival needs, or residing in substandard housing, homeless, or at imminent risk of becoming homeless.
 - Services are necessary for diversion from forensic hospitalization, pretrial release.
- Must have at least three of the following:
 - Evidence of coexisting mental illness and substance use disorder.
 - Significant suicidal ideation, with a plan and ability to carry out, within the last two years.
 - Suicide attempt in the last two years.
 - History of violence due to untreated mental illness or substance use within the last two years.
 - Lack of support systems.
 - History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability.
 - Threats of harm to others in the past two years.
 - History of significant psychotic symptomatology, such as command hallucinations to harm others.
 - Minimum Level of Care Utilization System score of three (3) at admission.

Exception criteria:

- The member does not meet medical necessity criteria above, but is recommended as appropriate to receive Assertive Community Treatment services by the member's health plan, the Assertive Community Treatment team leader, clinical director, and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness.

Service-specific criteria:

- Services are provided by an interdisciplinary Assertive Community Treatment team in accordance with national fidelity standards as evidenced by the Substance Abuse and Mental Health Services Administration Assertive Community Treatment Evidence-Based Practices toolkit (2008) or state requirements.
- Services are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and local practice standards, and not in excess of the member's needs.
- Services can be safely furnished, and no equally or more cost effective treatment is available statewide.
- Services are furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.
- **The Assertive Community Treatment team must provide six documented clinically meaningful face-to-face encounters with the majority of encounters occurring outside of the office, each month.**

- **For members transitioning from psychiatric or nursing facilities, the Assertive Community Treatment team must provide a minimum of four documented meaningful encounters a week for the 30 days post discharge/transition.**

Continued review criteria (must meet all of the following):

- Must have demonstrated member engagement and participation in treatment.
- The Assertive Community Treatment team must provide six documented clinically meaningful face-to-face encounters **per month** with the majority of encounters occurring outside of the office, over the authorization period.
- For members transitioning from a psychiatric or nursing facilities, the Assertive Community Treatment team must provide a minimum of four documented meaningful encounters a week **for the 30 days post discharge/transition** over the authorization period.
- Documentation of member's ability to benefit from treatment as evidenced by a monthly member report and updated individualized treatment plan within the last six months prior to the submission of the request for continued authorization.
- Must have a documented individualized discharge plan with projected discharge date.
- Must have documented evidence of service coordination, including medical and substance abuse needs, in service plan.

Discharge criteria:

Members whose functioning has improved to the point that they no longer require the level of services and supports typically rendered by an Assertive Community Treatment team, should be transitioned into a lower level of care. When making this determination, considerations should be made regarding the member's ability to be served within the lower level of care available to them. The team should begin implementing the discharge plan and preparing the member as functioning improves to the point that they no longer require the level of services and supports.

Discharge criteria (must meet one of the following):

- Completion of Assertive Community Treatment goals.
- Clinical improvement with evidence that goals can be met independent of Assertive Community Treatment services at a lower level of care.
- Member refuses to participate in services.
- Evidence that member no longer receives benefit from Assertive Community Treatment services (e.g. continued admissions to acute services and excessive use of emergency services).
- Inability to provide services to the member for 30 days or more for reasons of **unable to provide the minimally required contacts/month**, unable to locate, long-term incarceration, or long-term hospitalization.
- Evidence that the member has not been receiving Assertive Community Treatment services as described in the Louisiana Department of Health behavioral health manual (2021) for at least 60 days.

Limitations

All Assertive Community Treatment services require prior authorization.

The Plan reserves the right to conduct clinical record reviews of any Assertive Community Treatment services.

Any exceptions to the program requirements must obtain prior approval from the Plan.

Assertive Community Treatment providers must adhere to all programmatic standards detailed in the Louisiana Department of Health behavioral health services manual (2021) for providers.

Assertive Community Treatment services are comprehensive of all other services and shall not be billed in conjunction with the following services:

- Behavioral health services by licensed and unlicensed individuals, other than medication management and assessment.
- Residential services, including professional resource family care.

Alternative covered services

Intensive case management.

Background

Serious mental illness is a persistent mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities. In 2019, there were an estimated 13.1 million adults age 18 or older in the United States with serious mental illness, representing 5.2% of all U.S. adults (National Alliance on Mental Illness, 2021).

Examples of serious mental illness include major depressive disorder, schizophrenia, and bipolar disorder. Addiction disorder and/or a developmental disability may accompany serious mental illness. Individuals may experience frequent acute psychiatric episodes resulting in hospitalization or emergency room visits, interactions with law enforcement or imprisonment, suicidal ideation or attempts, or a history of violence related to their mental illness.

An adaptation of the federal Substance Abuse and Mental Health Services Administration (1993) definition provides more detailed eligibility criteria:

- Age 18 years or older.
- A diagnosable mental, behavioral, or emotional disorder that meets the sufficient duration to meet the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders — Fifth Edition*.
 - Substance use disorders, developmental disorders, and organic brain syndromes are excluded, unless they occur with a diagnosable serious mental illness.
- The mental illness has resulted in impairment that significantly interferes with or limits one or more of the following major life activities:
 - Activities of daily living.
 - Interpersonal functioning.
 - Concentration, persistence, and pace.
 - Adaptation to change.

Assertive Community Treatment

In the 1970s, researchers in Wisconsin recognized that, for patients with serious mental illness, the progress made in the inpatient setting was often lost when they moved back into the community (National Alliance on Mental Illness Minnesota, 2017). Researchers developed Assertive Community Treatment to address this need. Assertive Community Treatment is a service delivery model centered in a multidisciplinary, team-based approach that provides individualized, proactive behavioral health care services in the home or other community settings. The primary goals of the model are to lessen or eliminate the debilitating symptoms of mental illness, reduce recurrent acute episodes (hospital admissions), and to enhance quality of life and functioning.

Unlike case management, the Assertive Community Treatment team provides a comprehensive array of treatment, rehabilitative, and support services directly rather than through referrals. As a higher intensity model of service delivery than case management, Assertive Community Treatment is associated with a lower average caseload. Services are provided 24 hours - seven days a week, in the community setting, and with no time limitation. As a result, the Assertive Community Treatment team is often positioned to anticipate and avoid crises.

Assertive Community Treatment is also known as Program of Assertive Community Treatment, Community Support Programs, or Mobile Treatment Teams (National Alliance on Mental Illness Minnesota, 2017). Assertive Community Treatment services are designed for individuals with severe and persistent mental illness and the greatest level of functional impairment, and whose needs have not been adequately met by traditional approaches. Assertive Community Treatment is generally long-term and can form a basis for integrated programs.

Findings

For this policy, we included nine systematic reviews (Dieterich, 2017; Hopkin, 2018; Hunt, 2019; McDonagh, 2017; Penzenstadler, 2019; Ponka, 2020; Randall, 2015; Vanderlip, 2017; Vijverberg, 2017), two individual studies (Monroe-DeVita, 2018; Valenstein, 2013), and two guidelines (National Alliance on Mental Illness Minnesota, 2017; Substance Abuse and Mental Health Services Administration, 2008). The evidence from moderate-to-high-quality studies establishes Assertive Community Treatment as a cost-effective, community-based model of delivering treatment, rehabilitation, and supportive mental health services to adults living with serious mental illness or dual diagnoses, significant functional impairment, and complex needs (National Alliance on Mental Illness Minnesota, 2017; Substance Abuse and Mental Health Services Administration, 2008). From a societal perspective, the cost-effectiveness of Assertive Community Treatment lies primarily in its ability to improve housing stability and reduce inpatient and emergency mental health use, as its targeted population is often a heavy user of inpatient services and experiences the poorest quality of life (Ponka, 2020).

Assertive Community Treatment compares favorably to less intensive case management services with respect to patient and family satisfaction, reduction in hospitalization, housing stability, medication adherence, and management of substance abuse (Hunt, 2019; McDonagh, 2017; Randall, 2015; Valenstein, 2013). Its impact on incarceration avoidance is inconclusive (Hopkin, 2018). Its effectiveness in other cohorts (children and adolescents with severe mental illness or those with only substance use disorder) or when integrated with curriculum-based programs or primary care programs is not established (Monroe-DeVita, 2018; Penzenstadler, 2019; Vanderlip, 2017; Vijverberg, 2017). Based on the evidence review, an expansion of the patient selection criteria to non-adult populations or populations without a diagnosis of a serious mental illness is not supported.

The effectiveness of community-based interventions is related both to model intensity and the team's ability to address and advocate for the comprehensive needs of the participants. Secondary analyses stress the importance of reporting fidelity to the Assertive Community Treatment model in the research, as programs that adhere to the program components are more effective in reducing hospital use than programs with lower adherence (Dieterich, 2017; Penzenstadler, 2019; Ponka, 2020; Substance Abuse and Mental Health Services Administration, 2008). Standardized examination of critical program elements ensures consistent good practice standards, may explain the variance in effectiveness across programs, and allows more accurate comparison of interventions.

In 2022, we added a comparison ($n = 2,034$) of community mental health with versus without flexible Assertive Community Treatment. Patients in the Assertive Community Treatment group had more outpatient contacts but fewer admissions. There were no significant differences in total inpatient days, use of coercion, episodes of self-harm, or deaths (Nielsen, 2021).

We also added a cost-effectiveness analysis for 950 homeless individuals with serious mental illness, randomized to scattered-site housing with Assertive Community Treatment or treatment as usual, followed to 24 months. Most (69%) of the costs of the intervention were offset by savings in other costs (Latimer, 2020).

A seven-year follow-up of 527 persons in the same program showed those with high needs in the Assertive Community Treatment group had 34% and 36% reductions in visits to primary care and non-primary care practitioners, versus treatment as usual (Mejia-Lancheros, 2021). Assertive Community Treatment for those in the program with high needs reduced hospital days and emergency visits by 68% and 43%, respectively; no differences exist for those with medium needs (Lachaud, 2021).

References

On November 4, 2021, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “assertive community treatment,” “intensive case management,” and “serious mental illness.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

2/2021: initial review date and clinical policy effective date: 5/2021

10/2022: Updated Service-specific criteria, continued review criteria, discharge criteria and policy references.