Humana
Healthy Horizons
in Louisiana

LA.CLI.023 Assertive Community Treatment (ACT/FACT)

Effective Date:		Accountable Dept.:	LA Medicaid Utilization Management
Last Reviewed Date:	11/01/2023		

Summary of Changes:

Minor formatting, addition of “Career Profile” information, grammar modification. Annual Review. New Template.

Scope:

This policy applies to all Humana Healthy Horizons™ in Louisiana (Plan) associates who administer, review, or communicate covered physical and behavioral health benefits and services to eligible enrolled members.

Purpose:

This clinical coverage policy is to identify the clinical criteria and guidelines to review medical necessity and appropriateness for Assertive Community Treatment (ACT).

Policy:

Assertive Community Treatment (ACT) requires prior authorization, is based on medical necessity, and is a long-term form of multidisciplinary outpatient care that supports members who may have had multiple behavioral health issues. Assertive Community Treatment services are inclusive of 1) service coordination, 2) crisis assessment and intervention, 3) symptom assessment and management 4) individual counseling and psychotherapy, 5) medication prescription, administration, monitoring and documentation, 6) substance use treatment, 7) rehabilitation services to restore capacity to manage activities of daily living, 8) restoration of social, interpersonal relationship, and other skills needed to ensure the development of meaningful daily activities (can occur through supporting work and educational efforts in addition to linking to leisure activities, and 9) direct assistance to ensure that members obtain supportive housing, as appropriate.

Procedures:

Assertive Community Treatment (ACT) services are community-based therapeutic interventions that address the functional problems of members who have the most complex and/or pervasive conditions associated with serious mental illness. These interventions are strength-based and focused on supporting recovery through the restoration of functional daily living skills, building strengths, increasing independence, developing social connections and leisure opportunities, and reducing the symptoms of

their illness. Through these activities, the goal is to increase the member's ability to cope and relate to others while enhancing the member's highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas. These include, but are not limited to, supportive interventions to help maintain housing and employment, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination.

Employment services provided through ACT programming adhere to tenets of the Individual Placement and Support (IPS) model of supported employment. IPS is an evidence-based practice of supported employment for members with mental illness designed to enhance the quality of employment services and overall employment outcomes for members.

The primary goals of the ACT program and treatment regimen are:

1) To lessen or eliminate the debilitating symptoms of mental illness or co-occurring addiction disorders the member experiences and to minimize or prevent recurrent acute episodes of the illness;
2) To meet basic needs and enhance quality of life;
3) To improve functioning in adult social and employment rolls and activities;
4) To increase community tenure; and
5) To lessen the family's burden of providing care and support healthy family relationships.

Fundamental principles of this program are:

1) The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the member;
2) Services are provided in the community; and
3) The services are person-centered and individualized to each member.

Target Population:

ACT serves members eighteen (18) years of age or older who have a severe and persistent mental illness (SPMI) and members with co-occurring disorders listed in the diagnostic nomenclature (current diagnosis per DSM) that seriously impairs their functioning in the community.

The member must have one of the following diagnoses:

1) Schizophrenia;
2) Other psychotic disorder;
3) Bipolar disorder; and/or
4) Major depressive disorder.

These may also be accompanied by any of the following:

1) Substance use disorder; or
2) Developmental disability.

These may also include one or more of the following service needs:

1) Two (2) or more acute psychiatric hospitalization and/or four (4) or more emergency room visits in the last six (6) months;
2) Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life;
3) Two (2) or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment);
4) Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided;
5) One or more incarcerations in the past year related to mental illness and/or substance use (Forensic Assertive Community Treatment (FACT));
6) Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT); or
7) Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).

Must have one (1) of the following:

1) Inability to participate or remain engaged in or respond to traditional community based services;
2) Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless; or
3) Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT).

Must have at least three (3) of the following:

1) Evidence of co-existing mental illness and substance use disorder;
2) Significant suicidal ideation, together with a plan and the ability to carry out such a plan, within the last two (2) years;
3) Suicide attempt in the prior two (2) years;
4) History of violence due to untreated mental illness and/or substance use within the prior two (2) years;
5) Lack of support systems;
6) History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability;
7) Threats of harm to others in the prior two (2) years;
8) History of significant psychotic symptomatology, such as command hallucinations to harm others; or

9) Minimum LOCUS score of three (3) at admission.

Exception criteria:

1) The member does not meet the medical necessity criteria above but is recommended as appropriate to receive ACT services by the member's health plan, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness. Examples include:
   a. Members discharging from institutions such as nursing facilities, prisons, and/or inpatient psychiatric hospitals;
   b. Members with frequent incidence of emergency department (ED) presentations and/or involvement with crisis services; and
   c. Members identified as being part of the My Choice Louisiana Program target population who meet the following criteria, excluding those members with co- occurring SMI and dementia where dementia is the primary diagnosis:
      i. Medicaid-eligible members over age eighteen (18) with SMI currently residing in NF; or
      ii. Members over age eighteen (18) with SMI who are referred for a Pre- Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement on or after June 6, 2016.

~~Discharge~~ Criteria~~:~~
for Discharge from ~~Assertive Community Treatment/FACT is indicated when the member's~~Services Members whose functioning has improved to the point that they no longer require the level of services and ~~support~~supports typically rendered by an ~~ACT~~Assertive Community Treatment team~~.~~ ~~Discharge~~, shall begin the process to transition into a lower level of care. When making this determination ~~takes into account~~ , considerations shall be made regarding the member's ability to be served within ~~lower levels of care and when those~~ the lower ~~levels~~ level of care ~~are~~ available to ~~support the member's discharge.~~them. The ACT team ~~shall~~should begin implementing ~~a~~the discharge plan ~~for~~and preparing the member as ~~their~~ functioning improves to the point that they no longer require the level of services and supports.

ACT teams must formally assess member' needs for ACT services at least once every 6 months using the ACT Transition Assessment Scale, a tool that establishes criteria to help determine whether a consumer is ready to be placed on a graduation track to transition to a less intensive level of ~~an~~care. An individual may be placed within the graduation track if they are assessed at a one (1) or two (2) on all the scaled items. Graduations shall also be considered for individuals assessed at a one (1) or two (2) on all scaled items but assessed at a three (3) on the Activities of Daily Living item and three (3) or four (4) on the Community Integration item. Further, assess the

member's Motivation to Graduate or Transition from ACT, again considering graduations for individuals assessed at a three (3) or four (4) on this item. Teams are encouraged to continually assess the service needs of participants as the member's needs change.
It is imperative that graduation be gradual, planned and individualized with assured continuity of care. More specifically, ACT teams shall employ the following strategies regarding graduations:

1. Introduce the idea of graduation from the very beginning of the member's enrollment (even during the engagement phase) and continue the discussion throughout their enrollment;
2. Frame graduation within the larger process of the member's recovery, enhanced well-being and independence in life;
3. Involve ACT team members in a discussion of the individual's potential for graduation and plans necessary to ensure successful transition to a less intensive level of care;
4. Involve the member in all plans related to his/her graduation;
5. Assess the member's motivation for transition to the graduation track and provide motivational interviewing interventions as appropriate to increase their comfort and interest in the graduation;
6. Be prepared with appropriate interventions should consumer temporarily experience an increase in symptoms or begin to "backslide" on treatment goals in response to graduation plans;
7. Involve the member's social network, including their family or support of choice, in developing and reviewing their graduation plan to the extent approved by the participant;
8. Coordinate several meetings with member, relevant ACT team members, and new service provider to introduce the new provider as well as review the participant's current status, progress in ACT and future goals;
9. Temporarily overlap ACT services with those of new provider for 30-60 days; and
10. Monitor the member's status following transition and assist the new provider, as needed, especially for the next 30-60 days.

Teams shall ensure member participation in discharge activities, as evidenced by the following documentation:

1. The reasons for discharge as stated by the member and ACT team;
2. The participant's biopsychosocial status at discharge;
3. A written final evaluation summary of the member's progress toward the goals set forth in the person-centered treatment plan;

4. A plan developed in conjunction with the member for follow-up treatment after discharge; and
5. The signature of the member, their primary practitioner, the team leader and the psychiatric prescriber.

When clinically necessary, the team will make provisions for the expedited re-entry of discharged members as rapidly as possible. If immediate re-admission to the ACT team is not possible because of a full census, the provider will prioritize members who have graduated but need readmission toACT.

Exclusions:

Assertive Community Treatment/FACT is a multidisciplinary intensive outpatient care service. As such ACT services are comprehensive of all other services except:

1. Psychological evaluation or assessment, and
2. Medication management

Therefore, ACT cannot be billed in conjunction with the following services:

1. Behavioral health services by licensed and unlicensed individual, other than medication management and assessment; or
2. Residential services, including professional resource family care

Assessment:

A comprehensive person centered needs assessment must be completed within thirty (30) days of admission to the program. The assessment includes a complete history and ongoing assessment of the following:

1. Psychiatric history, status, and diagnosis;
2. Level of Care Utilization System (LOCUS);
3. Telesage Outcomes Measurement System, as appropriate;
4. Psychiatric evaluation;
5. Strengths assessment;
6. Housing and living situation;
7. ~~Vocational, educational~~Educational and social interests and capacities;
8. Self-care abilities;
9. Family and social relationships;
10. Family education and support needs;
11. Physical health;
12. Alcohol and drug use;
13. Legal situation; and
14. Personal and environmental resources.

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The ~~**Career Profile**~~career profile will be reviewed and updated as needed at least every six (6) months~~,~~ or more
often as~~ **may be**~~ appropriate to the needs of each member. Refusals to participate in and complete the career profile assessment process shall be documented within the case notes, showing efforts to engage and clinically appropriate reasons for non-~~**compliance.**~~ completion.

The LOCUS and psychiatric evaluation will be updated at least every six (6) months or as needed based on the needs of each member, with an additional LOCUS score being completed prior to discharge.

For members participating in FACT, the assessment will include items related to court orders, identified within thirty (30) days of admission and updated every ninety (90) days or as new court orders are received.

Treatment Plan:

~~A treatment plan, responsive to the member's preferences and choices must be developed and in place at the time services are rendered. The treatment plan will include input from all staff involved in treatment of the member, as well as involvement of the member and collateral others of the member's choosing. In addition, the plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the member's signature. Refusals must be documented. The treatment plan must integrate mental health and substance use services for members with cooccurring disorders. The treatment plan will be updated at least every~~ ~~**three six (6) (3)**~~ ~~months or as needed based on the needs of each member.~~

~~For members participating in FACT, the treatment plan will include items relevant for any specialized interventions, such as linkages with the forensic system for members involved in the judicial system.~~

Treatment plan development will include an exploration of the member's employment interests and shall be documented in the progress notes. For those individuals interested in employment, their treatment plan will include at least one vocational goal pertaining to job search, job placement, job supports, career development, or career advancement.

A tracking system is expected of each ACT team for services and time rendered for or on behalf of any member.

Each treatment plan must consist of the following:

1. Plans to address all psychiatric conditions;
2. The member's treatment goals and objectives (including target dates), preferred treatment approaches and related services;
3. The member's educational, vocational, social, wellness management, residential or recreational goals, associated concrete and measurable objectives and related services;

4. The member's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing; and
5. A crisis/relapse prevention plan, including an advance directive.

When psycho-pharmacological treatment is used, a specific treatment plan, including identification of target symptoms, medication, doses, and strategies to monitor and promote commitment to medication must be used.

Program Engagement Expectations:

The ACT program provides three levels of interaction with the participating members, including:

1. Face-to-face encounter – ACT team must provide a minimum of six (6) clinically meaningful face to face encounters with the member monthly with the majority of encounters occurring outside of the office. Encounters should address components of the member's treatment plan, involve active engagement with the member, and actively assess their functioning. Teams must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. Teams must also document reasons contacts are occurring within the office. Efforts shall be made to ensure services are provided throughout the month;
2. Collateral encounter – Collateral refers to members of the member's family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) who regularly interact with the member and are directly affected by, or have the capability of affecting, his or her condition and are identified in the treatment plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff person who is assisting an ACT member in locating housing); and
3. Assertive outreach – Refers to the ACT team being 'assertive' about knowing what is going on with a member and acting quickly and decisively when action is called for, while increasing member independence. The team must closely monitor the relationships that the member has within the community and intervene early if difficulty arises.

~~Additionally, ACT staff will document all encounters with participating members. The documentation should be thorough and meaningful based on the member's person-centered treatment plan and consistent with Dartmouth Assertive Community Treatment Scale (DACTS), which is an ACT Fidelity Scale found in the SAMHSA toolkit for ACT.~~ For those members transitioning from psychiatric or nursing facilities, ACT ~~team~~ staff must provide a minimum of four ~~(4)~~ encounters a week with the member during the ~~initial~~first thirty (30) days post transition ~~to~~into the community. Encounters should be meaningful per the guidance outlined above.

If ~~the~~this minimum number of encounters cannot be made, ACT ~~team~~ staff must document clinically appropriate reasons for why ~~the expected~~this number of encounters cannot ~~or were not~~be achieved~~.~~. The teams will provide comprehensive, individualized services, in an integrated, continuous

fashion, through a collaborative relationship with the member. The ACT program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance use and has gradual expectations for abstinence.
ACT teams will utilize IPS, an evidence-based supported employment model that is based upon eight basic principles that include the following:

1. Open to anyone who wants to work;
2. Focus on competitive employment;
3. Rapid job search;
4. Targeted job development;
5. Client preferences guide decisions;
6. Individualized long-term supports;
7. Integrated with treatment; and
8. Benefits counseling provided.

Each IPS Specialist carries out all phases of employment services; including completion of career profile, job search plan, job placement, job coaching, and follow-along supports before step-down from IPS into ongoing follow along provided through the ACT team through traditional service provision.

Members are not asked to complete any vocational evaluations, i.e. paper and pencil vocational tests, interest inventories, work samples, or situational assessments, or other types of assessment in order to receive assistance obtaining a competitive job.

A career profile is typically completed during 2-3 sessions, and should include information about the member's preferences, experiences, skills, strengths, personal contacts, etc. The career profile is reviewed and updated as needed with each new job experience and/or at least every six (6) months. The information may be provided by the member, treatment team, medical records, and with the member's permission, from family members, and previous employers. For new admissions, the initial career profile must be completed within thirty (30) days after admission to the ACT program.

For those individuals who have expressed an interest in employment, an individualized job search plan is developed with the member, and is updated with information from the career profile, and new job experiences. IPS specialists will visit employers systematically, based upon the member's preferences, to learn about the employer's needs and hiring preferences. Each IPS Specialist is to make at least six (6) face-to-face employer contacts per week, whether or not the member is present. IPS Specialist are to use a weekly tracking form to document their employer contacts. The first face-to-face contact with an employer by the member or the IPS Specialist shall occur within 30 days of the member entering the program.

IPS Specialists are to have a face-to-face meeting with the member within one (1) week before

starting a job, within three (3) days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by members. At this time, members are to be transitioned to step down job supports from a mental health worker following steady employment. If a need arises for more intense support by the IPS specialist, they will increase the number of interactions with the member.

IPS specialists contact members within three (3) days of learning about the job loss. IPS specialists also provide employer support (e.g., educational information, job accommodations) at a member's request.

IPS provides assistance to find another job, when one job has ended, regardless of the reason the job ended, or the number of jobs the member has had. Each job is viewed as a learning experience, and offers to help find a new job is based upon the lessons learned.

Job supports are individualized and continue for as long as the member wants and needs the support. Members receive different types of support based upon the job, member preferences, work history, and needs. The IPS Specialist may also assist the member to obtain the job accommodations necessary for the member to perform the job efficiently and effectively.

IPS Specialists ensure that members are offered comprehensive and personalized benefits planning, including information about how their work may affect their disability and government benefits, as both are based upon their income. These may include medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits, and other sources of income.

Service termination is not based on missed appointments or fixed time limits. Engagement and outreach attempts made by integrated ACT team members are systematically documented, including multiple home/community visits, coordinated visits by IPS specialist with integrated ACT team member, and contacts with family, when applicable. Once it is clear that the member no longer wants to work or continue with IPS services, the IPS Specialist shall review and update the career profile as needed every six (6) months; employment shall be screened every three (3) months as the treatment plan is updated.

Definitions:

~~Licensed Mental Health Professional (LMHP) – an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. An LMHP includes the following individuals who are licensed to practice independently:~~

~~1) Medical psychologists;~~
~~2) Licensed psychologists;~~
~~3) Licensed clinical social workers (LCSWs);~~
~~4) Licensed professional counselors (LPCs);~~
~~5) Licensed marriage and family therapists (LMFTs);~~
~~6) Licensed addiction counselors (LACs); and~~

~~7) Advanced practice registered nurses (APRNs).~~

None

Contract References:

Medicaid Managed Care Organization Contract Attachment A: Model Contract

References:

Louisiana Medicaid Managed Care Organization (MCO) Manual

Louisiana Department of Health, Louisiana Medicaid Behavioral Health Services Provider Manual: *Chapter Two of the Medicaid Services Manual*; Issued 08/17/22 BHS.pdf (lamedicaid.com). Accessed Oct. 25, 2022.

Version Control:

01/01/2023: Policy Creation-Approved by LDH for Readiness

02/24/2023: Reviewed and updated per LDH guidance by Samantha Pacheco, Patricia Jones.

11/01/2023: Annual Review and incorporation of MCO Manual updates as appropriate. Mike Gomila, Nicole Thibodeaux. New Template.

Owner:	Barbara McCarthy	Executive Team Member:	LORI DUNNE
Accountable VP / Director:	Nicole Thibodeaux		

Non-Compliance:

Failure to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services, or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules, and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet on Hi! (Workday & Apps/Associate Support Center).