Assertive Community Treatment

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 roles and activities through the provision of evidence-based employment supports;

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 ~~old~~ 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 i~~I~~nclude one or more of the following service needs:

1. Two (2) or more acute psychiatric hospitalizations 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 ~~last~~ prior two (2) years;

4. History of violence due to untreated mental illness and/or substance use within the ~~last~~ 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~~past~~ 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.

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. 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.

Utilizing the comprehensive person centered needs assessment, an initial vocational assessment (referred to as the "career profile") in addition to member interviews, shall be completed on all individuals participating in the ACT program within thirty (30) calendar days after program entry for members admitted on or after 10~~7~~/01/2023, or within ninety (90) calendar days for existing members. The career profile typically occurs over 2-3 sessions by the IPS employment specialist.

The 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-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 co-occurring disorders. The treatment plan will be updated every three (3) months or more often 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.

Services

Service provision for ACT will be based on the assessment and a recovery--focused and strengths based treatment plan. The teams will provide the following supports and services to members:

1. Crisis assessment and intervention;

2. Symptom management;

3. Individual counseling;

4. Medication administration, monitoring, education, and documentation;

5. Skills restoration to enable self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, nutrition and health, locating and maintaining a home, skills in landlord/tenant negotiations, and renter's rights and responsibilities;

6. Social and interpersonal skills rehabilitation necessary to participate in community based activities including but not limited to those necessary for functioning in a work, educational, leisure or other community environment;

7. Peer support, supporting strategies for symptom/behavior management. This occurs through providing expertise about the recovery process, peer counseling to

members with their families, as well as other rehabilitation and support functions as coordinated within the context of a comprehensive treatment plan;

8. Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management;

9. Referral and linkage or direct assistance to ensure that members obtain the basic necessities of daily life, including primary and specialty medical care, social and financial supports;

10. Education, support, and consultation to members' families and other major supports;

11. Monitoring and follow-up to help determine if services are being delivered as set forth in the treatment plan and if the services are adequate to address the member's changing needs or status;

12. Assist the member in applying for benefits. At a minimum, this includes Social Security Income, Medicaid and Patient Assistance Program enrollment;

13. For those members with forensic involvement, the team will liaise with the forensic coordinators as appropriate, further providing advocacy, education and linkage with the criminal justice system to ensure the member's needs are met in regards to their judicial involvement, and that they are compliant with the court orders; and

14. IPS services including ongoing exploration of employment interest, job search, job placement, job coaching, and follow-along supports.

Documentation shall be consistent with the Dartmouth Assertive Community Treatment Scale (DACTS), and the SAMHSA toolkit for ACT.

Criteria for Discharge from Services

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, shall begin the process to transition into a lower level of care. When making this determination, considerations shall be made regarding the member's ability to be served within the lower level of care available to them. The ACT 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.

ACT teams must formally assess member' needs for ACT services at least once every six (6) months using the ACT Transition Assessment Scale, a tool that establishes criteria to help determine whether a ~~consumer~~ member is ready to be placed on a graduation track to transition to a less intensive level of 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~~ the member 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 to ACT.

Program requirements

ACT services must be provided by an interdisciplinary team capable of providing the following:

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. This can occur through the provision of IPS services to support work and educational efforts in addition to linking to leisure activities; and

9. Direct assistance to ensure that members obtain supportive housing, as needed.

ACT is a medical psychosocial intervention program provided on the basis of the following principles:

1. The service is available twenty-four (24) hours a day, seven (7) days a week;

2. An individualized treatment plan and supports are developed;

3. At least ninety ~~(90)~~ percent (90%) of services are delivered as community-based outreach services;

4. An array of services are provided based on the member's medical need;

5. The service is member-directed; and

6. The service is recovery-oriented.

The ACT team must:

1. Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in crisis intervention (CI) procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone;

2. Provide mobilized CI in various environments, such as the member's home, schools, jails, homeless shelters, streets and other locations;

3. Arrange or assist members to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home;

4. Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff;

5. Ensure provision of culturally competent services; and

6. Conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures, including the following:

    a. Process measures related to ACT programming shall be obtained through utilization of the Dartmouth Assertive Community Treatment Scale (DACTS) and General Organizational Index (GOI);

    b. Concurrent to this process, fidelity to IPS programming shall be evaluated utilizing the Supported Employment Fidelity Scale found at https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf; and

    c. Outcome measures shall be collected via a standardized outcomes reporting instrument which is provided by and submitted to the MCOs monthly.

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 shall 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.

For those members transitioning from psychiatric or nursing facilities, ACT staff must provide a minimum of four (4) encounters a week with the member during the first thirty (30) days post transition into the community. Encounters should be meaningful per the guidance outlined above. If this minimum number of encounters cannot be made, ACT staff must document clinically appropriate reasons for why this number of encounters cannot 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.

Provider Qualifications and Responsibilities

ACT agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification by the accrediting body of such denial, loss of, or any negative change in accreditation status to the managed care entities with which the ACT agency contracts or is reimbursed.

NOTE: Effective March 14, 2017, ACT agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. ACT agencies must attain full accreditation within eighteen (18) months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must attain full

accreditation by September 14, 2018, i.e. eighteen (18) months from the initial effective date of the requirement for ACT agencies.

The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency. This includes successful completion of an LDH-approved Person Centered Planning training facilitated by the MCOs. New staff must complete the training within sixty (60) days of hire. Existing staff must complete the training by 6/30/24.

ACT agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on all provider responsibilities.

Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services twenty-four (24) hours a day, seven (7) days per week. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program member contact required by each member's treatment plan.

Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the member's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings. IPS specialists shall participate in these meetings at least weekly.

Each ACT team shall have a staff-to-member ratio that does not exceed 1:10. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained. All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each staff member receives training on the skills and competencies necessary to provide ACT services. Each staff member must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of LDH-approved trainings can satisfy this requirement.

Each ACT team shall include at least:

1. One (1) ACT team leader, who is a full time Licensed Mental Health Professional (LMHP) who must have both administrative and clinical skills;

2. One (1) prescriber, who can be either a board-certified or board-eligible psychiatrist, a medical psychologist, or an advanced practice registered nurse (APRN) with specialty in adult mental health and meeting the medical director requirements of licensure for Behavioral Health Service (BHS) providers;

   Note: In the event a medical psychologist or APRN are utilized, the team must be able to consult with psychiatrists.

3. Two (2) nurses, at least one (1) of whom shall be a RN. Both nurses must have experience in carrying out medical functioning activities such as basic health and medical assessment, education and coordination of health care, psychiatric medical assessment and treatment, and administration of psychotropic medication;

4. One other LMHP;

5. One substance use specialist, who has a minimum of one (1) year specialized substance use training or supervised experience;

6. One IPS specialist, who has successfully completed the OBH-approved IPS training prior to providing IPS services; at least one (1) year of specialized training or supervised experience;

7. One housing specialist, who has at least one (1) year of specialized training or supervised experience;

8. One peer specialist, who is self-identified as being in recovery from mental illness and/or substance use disorders who has successfully completed OBH required training and recognition requirements as a peer specialist; and

9. One IPS supervisor who has successfully completed the LDH-approved IPS training.

   a. This shall be a .20 FTE regardless of team size;

   b. This function can be fulfilled by the Team Leader; or an individual who supervises IPS specialists working within multiple ACT teams; and

   c. At least one (1) year experience in employment services, which includes any experience where they have worked in programs where they helped people find jobs.

In light of workforce shortages subsequent to the COVID-19 public health emergency, temporary modifications of these staffing requirements can occur in the event of employee turnover. However, ACT teams shall notify the MCOs in writing in the event of loss of staff and provide them with a written Corrective Action Plan for filling the position and ensuring member services are not impacted. This shall occur within seven (7) calendar days of staff separation. When the position is filled and the CAP can be lifted, the ACT team shall provide written notification of such to the MCO. Staffing levels shall increase proportional to the number of members served by the team in congruence with standards outlined within the DACTS.

ACT teams must meet national fidelity standards as outline within the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

Teams shall adhere to the following:

1. New teams:

    a. The ACT provider must notify the MCO in writing of its desire to create an additional team, including in this notification: justification for the creation of a new team and geographical location where the new team will operate.

        i. The MCO will investigate the need for an ACT team in the proposed geographic location and will inform the ACT provider in writing of the MCO's decision to approve or deny. If the MCO gives the ACT provider the approval to establish a new team, the provider will be required to follow the standard contracting/credentialing process with the MCOs in order to render services.

    b. The ACT provider must submit documentation to the MCO for contracting purposes including evidence of fidelity to the model including findings of self-evaluation using the DACTS/General Organizational Index (GOI) in addition to submitting the appropriate credentialing materials for vetting purposes and contact the MCO to ensure that all credentialing verification steps are met.

        i. The self-evaluation must reflect a minimum score of a 3.0 on the DACTS/GOI in order to be eligible to provide Medicaid funded services to members.

    c. The provider must also adhere to the following related to newly established teams:

i. Submit monthly outcomes reporting to the MCOs via a template provided by the MCOs.

ii. Undergo a fidelity review using the DACTS/GOI and the Supported Employment Fidelity Scale by an MCO-identified third party within six (6) months of implementation:

1. This review must reflect a minimum score of 3.0 on the DACTS/GOI in order to maintain certification and the ability to accept new members, be eligible to provide Medicaid funded services to members, and increase staff-to-member ratios;

2. If the MCO identifies a potential Quality of Care concern based on the data from the monthly Outcome Measures report the team may be subject to corrective action. The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2). This plan should be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members; and

3. If the fidelity review findings does not reflect a minimum overall score of 3.0 on the DACTS/GOI, the provider will forfeit any new referrals until an overall score of 3.0 is achieved. The provider will be permitted to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH. The team shall implement a remediation plan and undergo another fidelity review within three (3) months by the fidelity monitor. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals;

4. The Supported Employment Fidelity Scale review must reflect continued improvement toward the desired score of 100 (good fidelity); and

5. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

2. Existing teams:

a. Must submit monthly outcomes reporting to MCOs via a template provided by the MCOs;

b. Must participate in fidelity reviews using the DACTS/GOI conducted by the MCO or designee at least annually (every twelve (12) months) or more frequently as prescribed by the MCO;

c. The team will implement an MCO approved corrective action plan immediately for any individual DACTS criterion that rates a one (1) or two (2);

d. Must undergo a fidelity review using the Support Employment Fidelity Scale by an MCO-identified third party in conjunction with the DACTS/GOI fidelity review;

i. This review must reflect continued improvement toward the desired score of 100 (good fidelity);

ii. The team will implement an MCO approved corrective action plan immediately for any individual Supported Employment Fidelity Scale criterion that rates below 100 (good fidelity). This plan must be implemented within thirty (30) days of findings or sooner as determined necessary by the MCO to mitigate health and safety issues for members.

e. Must achieve a score of 3.0 and above on the DACTS/GOI in order to maintain certification and the ability to accept new clients;

f. If a score of 4.2 or higher on the DACTS/GOI is achieved, the team will be deemed as operating with “exceptional practice”:

i. MCOs may grant extensions of eighteen (18) month intervals between fidelity reviews for teams operating with "exceptional practice".

e. Operating below acceptable fidelity thresholds:

i. Teams, which achieve less than a 3.0 on the DACTS/GOI, will forfeit the ability to accept new members though they can continue to work with existing members as long as there are no health and safety violations with operations as determined by the MCO or LDH;

ii. Teams shall implement a remediation plan and undergo another fidelity review within three (3) months by the MCO or designee. This review will be at the cost of the provider. If the team achieves an overall score of 3.0 or greater on the DACTS/GOI in the subsequent review, the team can begin accepting new referrals; and

iii. If the team achieves more than a 3.0 on the DACTS/GOI in subsequent review, the team can begin accepting new referrals.

Allowed Provider Types and Specialties

PT AA Assertive Community Treatment Team, PS 8E CSoC/Behavioral Health.

Additional Service Criteria

ACT agencies must adhere to requirements established in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on provider responsibilities.

Exclusions

ACT services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a member receiving ACT services.

ACT shall not be billed in conjunction with the following services:

1. Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment; or

2. Residential services, including professional resource family care.

Billing

NOTE: Individualized substance use treatment will be provided to those members for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment.

The following activities may not be billed or considered the activity for which the ACT per diem is billed:

1. Time spent doing, attending, or participating in recreational activities;

2. Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or an academic tutor;

3. Habilitative services for the adult to acquire, retain, and improve the self-help, socialization and adaptive skills necessary to reside successfully in community settings;

4. Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;

5. Respite care;

6. Transportation for the individual or the individual's family. Services provided in the car are considered transportation;

7. Services provided to individuals under the age of 18;

8. Covered services that have not been rendered;

9. Services provided before approved authorization;

10. Services rendered that are not in accordance with an approved authorization;

11. Services not identified on the authorized treatment plan;

12. Services provided without prior authorization;

13. Services provided to the children, spouse, parents, or siblings of the eligible adult under treatment or others in the eligible member's life to address problems not directly related to the eligible member's issues and not listed on the eligible member's treatment plan;

14. Services provided that are not within the provider's scope of practice;

15. Any art, movement, dance, or drama therapies; and

16. Anything not included in the approved ACT services description.