

TEAM BASED SERVICES

Assertive Community Treatment (ACT)

SERVICE DEFINITION

Assertive Community Treatment (ACT) is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven (7) days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the ACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community. Typically this service should be targeted to individuals who have serious and persistent mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs.

The service objectives are addressed by activities designed to:

- promote symptom stability and appropriate use of medication;
- restore personal, community living and social skills;
- address and treat substance abuse issues;
- promote physical health;
- establish access to entitlements, housing, work and social opportunities; and
- promote the highest possible level of functioning in the community.

This team approach involves structured face-to-face in vivo therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, personal care, domestic, substance abuse, psychosocial, problem solving, etc. in preventing, overcoming, or managing the individual's level of functioning and enhancing his/her ability to remain in the community.

This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community.

ACT provides ongoing assertive outreach and treatment necessary to address individual's needs effectively. This model is primarily a mobile unit, but can include some clinic-based services.

The ACT team shall have the capacity to provide a minimum of three contacts a week with consumers 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, seven days per week and depend on individual need and a mutually agreed upon plan between the individual and ACT staff. Staff shall share responsibility for addressing the needs of all consumers requiring frequent contact. The ACT team shall provide a minimum three contacts per week for most consumers and all consumers shall receive a minimum of four (4) face-to-face contacts per month.

Source of Funding

Funding is provided by contract by Medicaid and non-Medicaid sources.

Modality/Location

The modality and location of services can be any of the following:

- onsite and offsite;
- face to face, telephone, video conference; and/or
- individual and limited amounts of group.

Included Activities and Interventions

1. Every ACT service must be provided exclusively by the ACT team.
2. The assessment must be completed within 30 days of entry into ACT with a reassessment completed annually. The goal of the ACT team assessment is to discover those factors which led to the failure of prior treatment attempts. Each part of the comprehensive assessment area shall be completed by an ACT team member with skill and knowledge in the area being assessed. The assessment is based upon all available information, including from individual interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within 30 days after an individual's admission according to the following requirements:
 - a. In collaboration with the individual, the ACT team will complete a psychiatric and social functioning history time line.
 - b. In collaboration with the individual, the comprehensive assessment shall include an evaluation in the following areas:
 - i. Identifying information: name, gender, date of birth, primary method of communication;
 - ii. Extent, nature, and severity of presenting problems;
 - iii. DSM-IV or ICD-9-CM diagnosis;
 - iv. Family history, including the history of mental illness in the family;
 - v. Mental status evaluation, including, at a minimum, attention, memory, information, attitudes, perceptual disturbances, thought content, speech, affect, suicidal or homicidal ideation, and an estimation of the ability and willingness to participate in treatment;
 - vi. Client preferences relating to services and desired treatment outcomes;
 - vii. Personal history, including mental illness and mental health treatment;
 - viii. History of abuse/trauma (childhood sexual or physical abuse, intimate partner violence, sexual assault or other forms of interpersonal violence);

- ix. Present level of functioning, including social adjustment and daily living skills;
 - x. Legal history and status, including guardianship and current court involvement;
 - xi. Assessment of risk, including the identification of factors which may endanger either the client or the client's family and other immediate threats to the client's personal safety (e.g., gang involvement, domestic violence, elder abuse);
 - xii. Education, specialized training, and vocational skills;
 - xiii. Employment history;
 - xiv. Interests, activities and hobbies;
 - xv. History of current alcohol or other substance use, abuse or dependence;
 - xvi. Name and contact information of the client's primary care physician;
 - xvii. Previous and current psychotropic medications, including date of most recent psychiatric evaluation;
 - xviii. General physical health, including date of last physical examination, any known symptoms or complaints, and current medications including over-the-counter medications;
 - xix. Resources such as family, community, living arrangements, religion, and personal client strengths; and
 - xx. Summary analysis, conclusions and recommendations for specific mental health services.
- c. Team based Assessment Process
- i. Psychiatric History, Mental Status, and Diagnosis: The psychiatrist is responsible for completing the psychiatric history, mental status, and diagnosis assessment. Using information derived from the evaluation, an LPHA shall make an accurate diagnosis from those listed in the American Psychiatric Association's DSM IV.
 - ii. Physical Health: A registered nurse (or LPN if agency meets grandfathering clause) is responsible for completing the physical health assessment.
 - iii. Use of Drugs and Alcohol: A team member with experience and training in dual diagnosis substance abuse assessment and treatment is responsible for completing the use of drugs and alcohol assessment.
 - iv. Education and Employment: A team member with experience and training in vocational assessment and services is responsible for completing the education and employment assessment.
 - v. Social Development and Functioning: A team member who is interested and skillful in attainment and restoration of social/interpersonal skills and relationships and who is knowledgeable about human development is responsible for completing the social development and functioning assessment
 - vi. Activities of Daily Living (ADL): Staff members with training to do the assessment and who have interest in and compassion for clients in this area may complete the ADL assessment.

- vii. Family Structure and Relationships: Members of the ACT team are responsible to carry out the family structure and relationships assessment.
- d. An admission note may be used to initiate services prior to the completion of a mental health assessment for a client who is admitted to ACT. An admission note must be completed within 24 hours after a client's admission and is effective for a maximum of 30 days. The admission note is a written report of an initial assessment and treatment plan and shall include the following:
 - i. Identifying information: name, gender, date of birth, primary language or method of communication, date of initiating assessment;
 - ii. Client's current mental health functioning level;
 - iii. Provisional diagnosis;
 - iv. Pertinent history;
 - v. Precautions (e.g., suicidal risk, homicidal risk, flight risk) and special programming to meet the client's needs;
 - vi. Initial treatment plan, including a list of Part 132 services that will be provided and the staff responsible for those services; and
 - vii. Other relevant information.

An admission note shall be completed by at least an MHP following a face-to-face or video conference meeting with the client. A QMHP shall be responsible for approving the completed admission note as documented by the QMHP's dated signature on the admission note.

3. Individualized treatment and recovery planning.
4. Peer Support Services: Services to validate individual's experiences and to guide and encourage them to take responsibility for and actively participate in their own recovery. In addition, services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma:
 - a. peer counseling and support, and
 - b. introduction and referral to self-help programs and advocacy organizations that promote recovery.
5. Service Coordination: Each individual will be assigned a primary service coordinator who coordinates and monitors the activities of the ACT team. Other staff of the ACT team shares these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Responsibilities can include:
 - a. working with the individual to write the treatment plan,
 - b. providing individual supportive counseling,
 - c. offering options and choices in the treatment plan,
 - d. ensuring that immediate changes are made as the individual's needs change,
 - e. advocating for the wishes, rights, and preferences,
 - f. serving as the primary point of contact when the individual is in crisis,
 - g. serving as the primary support person and educator to the individual's family, and
 - h. coordinating with community resources, including self-help and advocacy organizations that promote recovery.
6. Crisis Assessment and Intervention Services: Crisis assessment and intervention shall be provided by the team 24 hours a day, seven (7) days a week. These services will include telephone and face-to-face contact.

7. Symptom Assessment and Management: This shall include but is not limited to the following:
 - a. Ongoing comprehensive assessment of the individual's mental health symptoms, accurate diagnosis, and the individual's response to treatment.
 - b. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications.
 - c. Symptom management efforts directed to help each individual identify/target the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
8. Supportive counseling and psychotherapy, including generous psychological support to consumers, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.
9. Medication prescription, administration, monitoring, and documentation:
 - a. The ACT team Psychiatrist shall:
 - i. establish a clinical relationship with each individual,
 - ii. assess each individual's mental illness symptoms and provide verbal and written information about mental illness,
 - iii. make an accurate diagnosis based on the comprehensive assessment,
 - iv. provide education about medication, benefits and risks, and obtain informed consent, and
 - v. assess and document the individual's mental health symptoms and behavior in response to medication and monitor and document medication side effects.
 - b. All ACT team members shall assess and document the individual's mental health symptoms and behavior in response to medication and shall monitor for medication side effects.
10. Co-occurring substance abuse services, including:
 - a. Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has individual-determined goals. This shall include but is not limited to individual interventions in:
 - i. engagement (e.g., empathy, reflective listening, avoiding argumentation);
 - ii. assessment (e.g., stage of readiness to change, client-determined problem identification);
 - iii. motivational enhancement (e.g., developing discrepancies; psychoeducation);
 - iv. active treatment (e.g., cognitive skills training, community reinforcement); and
 - v. continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).
11. Work and education related services: Work and education related services to help individuals value, find and achieve meaningful employment or education in community-based job and education sites including but not necessarily limited to:
 - a. Mental Health Services that support work and education related recovery goals (billed to Medicaid)
 - i. Skill building activities that focus on the development of skills to be used by clients in their living, learning, social and working environments, which may include:

- a) Socialization, communication, adaptation, problem solving and coping;
- b) Self-management of symptoms or recovery;
- c) Concentration, endurance, attention, direction following, planning and organization; and
- d) Establishing or modifying habits and routines;
- ii. Assessment of the effect of the individual's mental illness on education and employment with identification of specific behaviors that interfere with the individual's school and/or work performance and development of interventions to reduce or eliminate those behaviors and find effective accommodations.
- iii. Individual supportive counseling/therapy to help the person identify and cope with mental illness symptoms that may interfere with their work or school performance.
- iv. On-the-job, at-school, or work/school-related crisis intervention.
- a. Work and education related services (not billed to Medicaid, but included as part of the ACT team function).
 - i. Talking about past and current and future employment goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.
 - ii. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
 - iii. Development of an ongoing educational and employment rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment.
 - iv. Work/school-specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc.
 - v. Job-specific supports such as teaching/coaching a job task, helping identify the pros and cons of disclosure or visiting the client at the job site to identify and address issues pertinent to job retention.
- 12. Activities of Daily Living: Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist consumers gain or use the skills required to:
 - a. find housing that is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate); landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities such as telephones, furnishings, linens;
 - b. perform household activities, including house cleaning, cooking, grocery shopping, and laundry;
 - c. carry out personal hygiene and grooming tasks, as needed;
 - d. develop or improve money-management skills;
 - e. use available transportation; and
 - f. have and effectively use a personal physician and dentist.

13. Social/Interpersonal Relationship and Leisure Time Skill Building: Services to support social/interpersonal relationships and leisure-time skill training (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 structure consumer's time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:
 - a. improve communication skills, develop assertiveness, and increase self-esteem;
 - b. develop social skills, increase social experiences, and develop meaningful personal relationships;
 - c. plan appropriate and productive use of leisure time;
 - d. relate to landlords, neighbors, and others effectively; and
 - e. familiarize themselves with available social and recreational opportunities in natural settings and increase their use of such opportunities.
14. Environmental and other Support Services: Support services or direct assistance to ensure that individuals obtain the basic necessities of daily life, including but not necessarily limited to:
 - a. medical and dental services;
 - b. safe, clean, affordable housing;
 - c. financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance)
 - d. social services;
 - e. transportation; and
 - f. legal advocacy and representation.
15. Services provided regularly to consumers' families and other major supports, with individual agreement or consent, include:
 - a. psychoeducation about the individual's illness and the role of the family and other significant people in the therapeutic process;
 - b. intervention to restore contact, resolve conflict, and achieve stable relationships with family and or other significant people;
 - c. ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family; and
 - d. introduction and referral to family self-help programs and advocacy organizations that promote recovery.

Service Requirements

1. Services must be available 24 hours a day, seven (7) days a week with emergency response coverage, including psychiatric coverage. Crisis services shall be provided 24 hours a day, seven (7) days a week by the ACT team assigned to the individual.
2. The following minimal contact standards apply:
 - a. A minimum of 75 percent of all team contacts (aggregate) shall occur in a natural setting.
 - b. A minimum of three contacts per week is provided for most consumers.
 - c. A minimum of four contacts per month is provided to all consumers.

3. Unplanned dropouts and involuntary closures are minimal (less than 10 percent). Team is persistent in engagement (i.e., at least two (2) face-to-face attempted contacts per week), continuing attempts for consumers who refuse services for a minimum of three (3) months.
4. The ACT team shall conduct organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings are attended by all team members assigned to be on duty with the exception of the psychiatrist(s) who should attend at a minimum of three (3) meetings per week. Meetings will review the status of all individuals via daily log, and develop a daily staff assignment schedule.
5. Services may be delivered by a single team member to two consumers at the same time if their goals are compatible; however this cannot be standard practice.
6. The only scenario in which ACT may be offered to more than two consumers is when a curriculum-based therapeutic group is offered such as DBT. For this to be allowable there must be an identified cohort of ACT participants whose clinical needs and recovery goals justify intervention by staff trained in the implementation of the specific curriculum-based milieu. This group may be offered to no more than eight ACT participants at one time and must be directed by no fewer than two staff in order to be billed as ACT. This may be offered no more than two (2) hours in any given week.
7. The ACT team program shall establish medication policies and procedures which identify processes to:
 - a. record physician orders;
 - b. order medication;
 - c. arrange for all individual medications to be organized by the team and integrated into consumers' weekly schedules and daily staff assignment schedules;
 - d. provide security for medications (e.g., daily and longer-term supplies and long-term injectibles) and set aside a private designated area for set up of medications by the team's nursing staff; and
 - e. administer medications per state law to clients.

Staffing Requirements

The minimum size for an ACT team is at least six (6) full time staff excluding the psychiatrist and program assistant. All teams are required to have, at a minimum:

1. Full time team leader who is the clinical and administrative supervisor of the team and who also functions as an ACT clinician. The team leader shall be a licensed clinician.
2. A psychiatrist who works on a full or part time basis for a minimum of 10 hours per week for every 60 consumers. The psychiatrist must provide clinical and crisis services to all team members, work with the team leader to monitor each individual's clinical and medical status and response to treatment, and direct psychopharmacologic and medical treatment. With a certification waiver, an Advanced Practice Nurse may substitute for up to half of the psychiatrist time.
3. A full time registered nurse who provides services to all ACT consumers and who works with the ACT team to monitor each individual's clinical status and response to treatment. The registered nurse functions as a primary practitioner on each ACT team for a caseload of consumers. Existing ACT providers may use an LPN with two

years experience in mental health services as part of an ACT team until July 1, 2009. New ACT providers shall be required to utilize an RN on all ACT teams.

4. Four staff who work under the supervision of a licensed clinician and function as primary practitioners for a caseload of consumers and who provide rehabilitation and support functions;
5. A program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individual.
6. At least one of the members of the core team must have special training and certification in substance abuse treatment and/or treating persons with co-occurring disorders.
7. At least one member of the team should be an individual in recovery and, if available, be credentialed as a Certified Recovery Support Specialist. This staff person is a fully integrated ACT team member who provides consultation to the ACT team, highly individualized services in the community, and who promotes self-determination and decision making.
8. At least one member of the core team must have special training in rehabilitation counseling, especially vocational, work readiness, and educational support.
9. Each team is expected to maintain a staff to individual ratio of no more than one (1) staff person per 10 consumers (excluding the psychiatrist and program assistant). As the number of consumers increase, teams must add staff to maintain this ratio.
10. Each team is expected to reflect the language, culture, and ethnicity of the population being served.

Service Exclusions

ACT may not be billed in combination with other Rule 132 services, with the exception that preapproved services may be billed on an individual basis and in accordance with a treatment plan in order to facilitate transition to and from the ACT service. This allowable transition time will be subject to public payer prior authorization and will be limited to 30 days.

Documentation Requirements

All documentation will be prepared and delivered in accordance with the requirements of Rule 132. In addition:

1. The ACT team shall conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader. The ACT team shall maintain a written daily log, using either a notebook, cardex, MIS system database. The daily log will provide a roster of the clients served in the program, and for each client, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the client's status that day.
2. The ACT team shall maintain and review as a part of the treatment planning and review process a consumer developed Crisis Plan.

Admission Criteria

DHS/DMH or its designee shall authorize ACT services for eligible consumers who meet the following criteria:

Eligible Population

Adults (age 18 or older) affected by a serious mental illness requiring assertive outreach and support in order to remain connected with necessary mental health and support services and to achieve stable community living. The program is inclusive of young adults who have met criteria for ICG if they meet other conditions listed below. Priority is given to persons affected by schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Consumers with other major psychiatric disorders may be eligible when other services have not been effective in meeting their needs. Eligible persons will be affected by one of the following diagnosis:

1. Schizophrenia (295.xx)
2. Schizophreniform Disorder (295.4x)
3. Schizo-Affective Disorder (295.7)
4. Delusional Disorder (297.1)
5. Shared Psychotic Disorder (297.3)
6. Brief Psychotic Disorder (298.8)
7. Psychotic Disorder NOS (298.9)
8. Bipolar Disorder (296.xx; 296.4x; 296.5x; 296.7; 296.8; 296.89; 296.9)

Symptom and Functional Indicators

1. Additionally the person must be someone for whom traditional services and modes of delivery have not been effective, and the individual should have one or more of the following problems that are indicators of a need for continuous high level of services (i.e., greater than eight hours per month):
 - a. Two or more psychiatric inpatient readmissions over a 12 month period or one long- term hospitalization of 180 days or more (Source: NAMI PACT Criteria)
 - b. Excessive use (2 or more visits in a 30 day period) of crisis/emergency services with failed linkages.
 - c. Chronic homelessness
 - d. Repeat (2 or more in a 90 day period) arrests and incarceration for offenses related to mental illness such as trespassing, vagrancy or other minor offenses.
 - e. Consumers with multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers.
 - f. Consumers who exhibit continuous functional deficits in achieving treatment continuity, self-management of prescription medication, or independent community living skills.
 - g. Consumers with persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate.
- a. The person must be someone with significant impairments as a result of their mental illness. Typically the consumer has a LOCUS composite score of 4 and above as scored prior to admission into the ACT program.

- b. Consumers with 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; achieving good 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 achieving 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) or of achieving consistent educational placement (depending on developmental level).
 - c. Significant difficulty achieving a safe living situation (e.g., repeated evictions or loss of housing).

Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder.

Exceptions to these criteria may be submitted for authorization consideration but will require additional clinical documentation and justification from the provider.

Continued Stay Service Criteria

The following criteria are necessary for continuing treatment with ACT services:

1. The person's severity of illness and resulting impairment continues to require ACT.
2. Services are consistent with the person's recovery goals and are focused on reintegration of the individual into the community and improving his/her functioning in order to reduce unnecessary utilization of more intensive treatment alternatives (e.g., residential or inpatient).
3. The mode, intensity, and frequency of treatment are appropriate.
4. Active treatment is occurring and continued progress toward goals is anticipated.
5. Treatment planning is individualized and appropriate to the individual's changing condition, and include the following as appropriate to stabilize and improve functioning:
 - a. outreach (e.g., linkage with community agencies, educational presentations);
 - b. assistance and referral with meeting basic needs (e.g., housing, food, medical care);
 - c. psychosocial evaluation and treatment;
 - d. crisis intervention;
 - e. social rehabilitation;
 - f. individual and family support and education (e.g., symptom management);
 - g. coordination and development of alternative support systems (e.g., religious organizations, self-help groups, peer support);
 - h. protection and advocacy resources;
 - i. coordination of services, including vocational, medical, and educational needs;and

- j. medication and treatment monitoring.
- 6. The services listed in 5 a-j are provided as needed and agreed upon in the treatment plan by providers and the individual.
- 7. The individual continues to require services in order to maximize functioning and sustain recovery or the individual's support network (e.g., family, friends, and peers) is insufficient to allow for independent living. (This usually is evidenced by a LOCUS composite score of 4 or above- explain variations as needed)

INITIAL (NEW) ACT AUTHORIZATION PROCESS

To request an authorization for a consumer who is not currently receiving ACT, the treating provider will submit a complete request for authorization of ACT packet that includes:

1. The ACT Authorization Request Form revised 1/14/08 that includes LOCUS information for adults
2. A treatment plan, including the treatment plan options of
 - a. An initial treatment plan with ACT listed as a service, or
 - b. A treatment recommendation from a comprehensive assessment not completed by the ACT team (This assessment and treatment recommendation can also come from a hospital facility or another community provider
3. The consumer's initial crisis plan

Once the initial ACT request is submitted, the documents will be reviewed for adherence to the clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services the Collaborative will enter an initial authorization for 90 days of services.

A LOCUS assessment needs to be completed as part of the authorization request. Typically a composite score of 4 indicates that the individual's needs are so pervasive and/or unpredictable, it is unlikely that other combinations of available community services have been or would be effective. There is a section on the request form where the provider can explain the variance between the clinical presentation and a LOCUS score below 4. Typically the LOCUS score is updated at the time of a treatment plan review, when a consumer is discontinuing services or when the consumer's clinical condition warrants.

Providers are to complete the comprehensive team based assessment and the ACT treatment plan within the first 30 days of ACT services. Before the initial authorization expires, the ACT team is to submit a reauthorization request if the consumer continues to need ACT services. This request should be submitted within two weeks of the initial authorization expiration date.

REAUTHORIZATION PROCESS FOR ACT

To request a reauthorization for a consumer who is currently receiving ACT, the treating provider will submit a complete request for authorization of ACT packet that includes:

1. The ACT Authorization Request Form that includes LOCUS information for adults.
2. An updated ACT treatment plan based on the comprehensive assessment inclusive of specific addendums completed by the ACT team, and
3. The consumer's crisis plan.

Once the request for reauthorization of ACT services is submitted, the documents will be reviewed for adherence to clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services, the Collaborative will enter an authorization for up to 180 days of services.

If the clinical criteria are not met, the Collaborative will either authorize a 30 day transition period or the Collaborative will deny the requested service.

Before the reauthorization expires, the ACT team is to submit a reauthorization request if the consumer continues to need ACT services. This request should be submitted within two weeks prior to the current authorization expiration date.

Transition from ACT Services

When a consumer is transitioning into or out of ACT, other mental health services can be provided (in addition to ACT) when clinically indicated for a period of 30 days.

In order to facilitate reimbursement, the ACT provider must submit an updated Request for Authorization for ACT completing the Transition Plan section and indicating the additional services that are clinically indicated. These additional services should also be included on the Individualized Treatment Plan. Examples of when this may occur include:

1. Crisis Residential: When an individual requires crisis residential to avert a hospitalization, ACT services should continue in addition to the residential services. The provider should indicate the need for Community Support Residential and any other services that the client requires during the crisis residential stay.
2. Community Services: When an individual is being transitioned to an array of outpatient services (for example, PSR, Community Support, Counseling, and Medication Management). The ACT provider should indicate the specific services to which the client is being transitioned.
3. Community Support Team: When an individual is being transitioned to Community Support Team, CST should be indicated in the Transition Plan of the Request for Authorization for ACT form. In addition, a Request for Authorization for CST form must be submitted by the CST provider.

Discontinuation of ACT services:

Providers must notify the Collaborative when a consumer is discontinuing ACT services by completing a "Notification of Discontinuance of ACT Services" form and faxing it to the Collaborative or by entering the information in ProviderConnect

Discontinuance of ACT services shall occur when:

1. Person requests termination from ACT and is currently stable
2. Person has improved to the extent that ACT is no longer needed and recovery goals have been met. (No medical necessity for ACT – indicate transition plan on Notification of Discontinuance form.)
3. Person has moved out of the ACT teams' geographic area (provide linkage information to the new ACT team or community service)
4. Person has moved out of State (make attempts to link with other ACT or community services)
5. Person cannot be located, in spite of repeated ACT efforts. (Describe efforts to locate and continue ACT services such as number of failed contacts, time elapsed since last contact, lack of leads on whereabouts from the person's emergency contact list)
6. Person is deceased.

Detailed information regarding discontinuance of ACT services and linkage to other services must be documented in the consumer's clinical record.

Reasons for Medical Necessity denials of ACT services

The consumer does not evidence each of the following as described in Rule 132 and the Authorization Protocol developed by DHS/DMH:

- The individual is not affected by a diagnosis referenced in Rule 132 for this service request
- There is not evidence that the individual is someone for whom traditional services and modes of delivery have not been effective
- There is not evidence of significant impairments as a result of a mental illness supported by the LOCUS composite score
- There is not evidence of significant functional impairment