Division Criteria for the Certification of Assertive Community Treatment (ACT) Teams

Providers will be required to have applicable policies & procedures per NAC 458 / Division Criteria and a program description which will be noted in the P&P section of the certification report. Providers will be required to adhere to applicable sections of NAC 458 / Division Criteria related to clinical and treatment protocols.

Definition of ACT:
Assertive Community Treatment (ACT) is an evidenced based practice designed to assist individuals with Serious Mental Illness (SMI), and/or SMI with Co-Occurring Disorders. Individuals most appropriate for ACT services are primarily those who have an SMI and have also been diagnosed with one or more of the following:

- Major depression;
- Schizophrenia;
- Bipolar disorder;
- Obsessive compulsive disorder;
- Panic disorder;
- Post-traumatic stress disorder;
- Borderline personality disorder;
- Co-occurring substance use/mental health disorders and who struggle living independently within the community;

Individuals most appropriate for ACT services meet at least one of the following indicators for high-service needs:

- High utilization of emergency services (generally 2 or more admissions per year for psychiatric emergency services or psychiatric inpatient hospitalization); which could include calling crisis phone line, accessing emergency room services and accessing psychiatric hospital services;
- Have housing instability (i.e. substandard housing, homeless or imminent risk of becoming homeless);
- Have legal issues (i.e. arrest and/or incarceration that can be related to a mental health or co-occurring disorder); and/or
- Have been unsuccessful in traditional treatment models, per clinical record or staff report.

The ACT model is a team-based, multidisciplinary treatment approach that is capable of being more flexible based upon individual needs than a more traditional model. This multidisciplinary treatment program should provide intensive wrap around services within the assembled team rather than referring to external providers. Due to the intensity of the ACT service model, the client to staff ratios are limited. Full time staff to client ratio is 1 to 10 in urban communities and 1 to 12 in rural communities. ACT Teams need to start with a minimum of 5 staff members and work towards the 1 to 10 (urban) and 1 to 12 (rural) staff to client ratio as their consumer numbers increase. Services are available 24 hours a day, 7 days a week and 365 days a year. Furthermore, services are provided primarily within the community and home-based settings. A minimum of 75% of direct contact hours, should occur within the community and home-based setting as participants are encouraged to engage within their environment throughout services. Clients residing in urban areas can receive contact multiple times per day, daily. In rural areas, clients may receive extended individual contacts with less frequency due to geography, but

contact must occur a minimum of 1 time every 2 weeks depending on assessment of current symptom severity.

ACT Team Safety Plan:
Due to the nature of the ACT model of providing services in the community where recipients live, work, and socialize, the safety of the staff in the community is an important feature of the model. The agency must develop a comprehensive safety plan specific to the ACT team and ensure that all staff are trained in community safety and actively follow the safety plan. This plan will be noted in the policy and procedure section of the certification report and should also be incorporated into the agencies Quality Assurance Plan.

ACT Team Staffing:
All ACT teams must begin with at least 5 full-time staff. The multidisciplinary staffing model shall include the following three key personnel:

- Team leader - Licensed Mental Health or Co-Occurring Disorder (COD) Qualified Professional,
- Psychiatric Prescriber in an urban setting (1 per 100 patients); Psychiatric Prescriber in a rural setting (1 per 100 patients),
- Registered Nurse (2 per 100 consumers),

The remaining team members can be a combination of the following list that best reflects the needs of your ACT program clients (If the Team Leader is not COD qualified, then at least one of the remaining team positions must be a Masters Level Substance Use Disorder Treatment Specialist):

- Supportive Employment Specialist (internal or by care coordination*; 2 per 100 consumers),
- Masters Level Substance Use Disorder Treatment Specialist,
- Masters Level Mental Health or Co-Occurring Counselor,
- Peer Recovery Support Specialist,
- Case Manager (Bachelors level position),
- Program or administrative support staff

*Potential exceptions due to staffing shortages:

- If a program is unable to attain a full-time psychiatric prescriber or full-time nurse due to staffing shortages, the ACT program may hire these positions as part-time. The ACT program must then also hire additional staff to complete a team composition that is equal to 5 full-time staff (e.g. an ACT with both the psychiatric prescriber and nurse working 50% FTE may require a staff of 7 people to meet the minimum staffing requirement).

- If Supportive Employment Specialist is not a part of the initial team composition and/or if programs are unable to staff this position, then programs may refer out for Supportive Employment Services. Organizations referring services to external providers will need to provide formal coordinated care agreements, listing the specific services being offered by the external provider(s) such as vocational training, employment assistance, and educational assistance for example. Supportive Employment Services is a required component of the ACT Model.

NOTE: If one of the required ACT Team member positions is vacant longer than 2 weeks the Provider will notify the Division of the vacancy and the plan to fill the position.

Staffing / Care Coordination Definitions:
All team members requiring licenses/certifications will need to be a member in good standing with the Nevada Board in which their license.

Team Leader: Full-time team leader/supervisor who serves as the clinical and administrative supervisor of the team and who functions as a practicing clinician on the ACT team. Team leader must carry a valid Nevada clinical license in nursing, social work, marriage and family therapy, certified professional counseling, psychiatry, clinical psychology, or be a psychiatric prescriber.

Psychiatric Prescriber: May include a psychiatrist or a psychiatric nurse practitioner. Psychiatric Prescriber may work full or part time for a minimum of 16 hours per week for every 50 consumers. The Prescriber provides medically managed services to all ACT participants; works with the team leader to monitor each participant's clinical status and response to treatment; supervises staff delivery of medical services; and directs psychopharmacologic and medical services. In addition, the Prescriber must review the Prescription Drug Monitoring Program (PDMP) prior to prescribing medication.

Registered Nurse: Is responsible for assessing physical needs; making appropriate referrals to community physicians; providing management and administration of medication in conjunction with the psychiatric prescriber; providing a range of treatment, rehabilitation, and support services. Though biomedical assessments and treatment are likely, the primary responsibilities are psychiatric, not medical.

Supportive Employment Specialist: Is responsible for integrating vocational goals and services within the treatment plan. Will provide needed assistance through all phases of the vocational service in addition to performing routine team duties. If Supportive Employment services are contracted out, the contractor will need to have frequent contact with the ACT Team and this may be in lieu of attending the ACT Team meetings.

Master's Level Substance Use Disorder Specialist: Must hold a license or certification to provide, at a minimum, substance use disorder treatment services; responsible for integrating co-occurring treatment within the treatment plan.

Peer Recovery Support Specialist (per Medicaid Services Manual 400): Serve as a role model, educate participants about self-help techniques and self-help group processes, teach effective coping strategies based on personal experience, teach symptom management skills, assist with clarifying rehabilitation and recovery goals, and assist in the development of community support systems and networks.

Case Manager: Minimum of a bachelor's level degree in social work, or a behavioral science program and experience working with adults with serious mental illness. Will provide services including coordination of services and support services.

Program or Administrative Support Staff: Responsible for organizing, coordinating, and monitoring all nonclinical operations including managing medical records; maintaining

accounting and budget records for participants and the program; and performing receptionist activities.

Staffing Training:

ACT Teams must view required training webinars and may contact CASAT at ACT@casat.org to obtain a link or participate and show verification of the following training through an accredited/approved institution or vendor. ACT Staff records must contain verification of the following evidence-based training:

- Assertive Community Treatment Team Model
- Integrated Dual Disorder Treatment (IDDT)
- Focus on Integrated Treatment (FIT)
- Trauma Informed Care
- Motivational Interviewing (MI)
- Crisis Management and De-escalation Approaches
- American Society of Addiction Medicine (ASAM) / Level of Care Utilization System (LOCUS)

ACT Service Delivery:

Services shall be individually tailored to meet the needs of each client based on their input through relationships built with ACT Team members and medical necessity. Services that are expected to be provided within the team, as directed within an individualized treatment plan, include, but are not limited to:

- Crisis Assessment and intervention
- Comprehensive evaluation for mental health and Co-Occurring Care
- Substance Use Treatment
- Psychiatric care
- Case management
- Medication administration and management
- Illness management and recovery skills
- Individual supportive therapy
- Supportive Employment services such as pursuing education or vocational training
- Assistance with activities of daily living such as skill development addressing housing performing household activities, personal hygiene and grooming tasks, money management, accessing and using transportation resources, accessing medical or dental resources and accessing other applicable benefits
- Intervention with family and natural supports
- Coordination of care between team members and/or external services
- Housing assistance

ACT Service Definitions:

Crisis Assessment and Intervention: services that are offered 24 hours per day, seven days a week for participants who are at risk of and/or experiencing a crisis. Crisis is defined as immediate harm to self or others. The goal of the ACT Team with consistent contact and communication with the client is to intervene when a client is decompensating prior to the need of hospitalization.

Comprehensive Evaluation: a comprehensive assessment that addresses current and past information from the participant and family and/or support systems regarding:

1. mental and functional status;
2. effectiveness of past treatment;
3. current treatment, rehabilitation and support needs to achieve individual goals and support recovery;
4. individual strengths that can act as resources towards achieving individual goals; and
5. substance use history, treatment history.

The information gathered is used to:

1. establish appropriate intensity of care;
2. set initial goals and develop the first person-centered treatment plan; and
3. plan of utilization of client strengths and support network in treatment. [See NAC 458 and associated Division Criteria related to Clinical Evaluation and Assessment].

Psychiatric Care: includes psychiatric medical assessment, treatment and education regarding a participant's mental health and substance use issues.

Case Management: Case management services are services which assist an individual in gaining access to needed medical, social, educational and other supportive services and must include the following components:

1. Assessment of the eligible individual to determine service needs.
2. Development of a person-centered care plan.
3. Referral and related activities to help the individual obtain needed services.
4. Monitoring and follow-up.

Medication Administration and Management: a collaborative effort between the participant and the psychiatric prescriber with the participation of the ACT team to evaluate the participant's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other mediation; to choose a medication treatment; and to establish a method to prescribe and evaluate medication according to evidence-based practice standards.

Illness Management and Recovery Skills: combination of psychosocial approaches facilitating the learning and use of illness self-management strategies that help people make progress towards personally meaningful goals including relapse prevention planning, coping skills training, illness education, and promoting a healthy lifestyle.

Individual Supportive Therapy: includes psychotherapies that help people make changes in their feelings, thoughts, and behavior to move towards recovery, clarify goals, and address stigma. Supportive therapy and psychotherapy also help participants understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and evaluate treatment and rehabilitative services.

Supportive Employment: includes work-related services to help participants value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers.

Family and Natural Supports: includes psychoeducation and support in partnership with families and natural supports (supportive services built in their community in which the individual

accesses, i.e. church, stable housing) to provide current information about mental illness and to help them develop coping skills for handling problems posed by mental illness as experienced by a significant other in their lives.

Coordination of Care between team members and/or external services: a process of organization and coordination within the transdisciplinary team to carry out the range of treatment, rehabilitation, and support services based upon the individualized treatment plan for each participant. Service coordination also includes coordination with community resources, including self-help and advocacy organizations that promote recovery.

Housing Assistance: varies based upon individual needs. It may include finding safe, affordable housing, negotiating leases and assisting clients in paying their rent, purchasing and repairing household items, or developing relationships with landlords.

Care Coordination:
ACT teams will be expected to build relationships and formal agreements for assuring service continuity with other systems of care including:

- Emergency service programs
- State and local psychiatric hospitals
- Rehabilitation services
- Housing agencies
- Social services
- Educational institutions
- Self-help/peer run services
- Independent living centers
- Natural community supports, including parenting programs, churches/spiritual centers and local groups/organizations
- Local law enforcement, correctional facilities and organizations such as parole and probation

ACT Admission and Discharge Criteria:
Admission decisions must be made within seven (7) business days of receiving the initial referral and refusal to take medication is not a sufficient reason for denying admission. Admissions should not exceed 4-6 clients per month for new ACT Teams to gradually build up capacity to service no more than 80-100 urban participants and no more than 42-50 rural participants.

The first several weeks following admission requires the most intensive services including completion of the assessment and beginning to address any unmet needs (e.g. housing, public assistance, medical care and stabilizing psychiatric symptoms).

Admission guidelines for ACT programs per NAC 458 are, at a minimum, LOCUS Level IV / ASAM Level 1 Outpatient with a focus on participants with mental illnesses and/or COD that seriously impair their ability to successfully function in their community. Significant functional impairments (as identified by SAMHSA) include at minimum one of the following:

- Consistent inability to perform practical daily tasks needed to function in the community:
    - Maintaining personal hygiene;
    - Meeting nutritional needs;

    - Caring for personal business affairs;
    - Obtaining medical, legal, and housing services; and
    - Recognizing and avoiding common dangers for hazards to one's self and one's possessions.
- Persistent or recurrent failure to perform daily living tasks, except with significant support from others;
- Consistent inability to maintain employment at a self-sustaining level or carry out homemaker roles; and
- Inability to maintain a safe living situation (e.g. repeated evictions or loss of housing).

Others who receive prioritization include those who:

- Have engaged in high acute psychiatric hospitalization (e.g. two or more admissions per year) or psychiatric emergency services;
- Persistent or recurrent severe mental health symptoms (e.g. affective, psychotic, suicidal);
- Coexisting substance-use disorder of significant duration (e.g. greater than 6 months);
- High risk or a recent history of being involved in the criminal justice system;
- In substandard housing, homeless, or at imminent risk of becoming homeless;
- Living in an inpatient facility or supervised community residence but assessed to be capable of living independently with assistance of intensive services; and
- Inability to participate in traditional office-based services.

Discharge guidelines contain no time constraints for the length of program participation. [Note: refusal to take medication is not a sufficient reason for discharge].

Discharges from the ACT occur when the participant and staff mutually agree to the termination of services. Discharge guidelines for ACT programs will be established specific to NAC 458 / Division Criteria. This will occur when:

- Participants demonstrate, over a minimum period of one year, the ability to function in major role areas (i.e. work, social, self-care).
- Participants move outside of the ACT team geographic area of responsibility. In such a case, the team is responsible for arranging for a transfer of services to an appropriate provider and will maintain contact with the participant until the transfer is established.
- Participants decline or refuse services and request a discharge, despite the teams repeated efforts to engage. For those with a history of harm to self or others alternative treatment should be arranged.

In addition to the mutually agreed upon discharge criteria, participants may be discharged for any one of the following circumstances:

- Deceased.
- Long-term hospitalization or incarceration for three months or longer. Provisions will be made for these individuals to reengage in services upon their release.
- Inability to locate the participant for a minimum of 3 months.

Program Fidelity Evaluation / Quality Assurance Monitoring:

ACT teams will be evaluated annually utilizing a fidelity and/or quality assurance tool with considerations for rural locations, number of participants, and staffing availability. Possible

tools include for Urban teams: the Dartmouth Assertive Community Treatment Scale (DACTS) Model, and for rural teams: the South Dakota Model.

The ACT Team should meet at a minimum 4 days per week to review each client, to address any concerns as they arise and to review / revise current treatment plans. At least 90% or more participants should have face-to-face interaction with more than one member of the ACT team every 2 weeks. A minimum of 75% of services provided should result in data reflecting face-to-face contact in the community or home setting. In rural areas, clients may receive extended individual contacts with less frequency due to geography, but contact must occur a minimum of 1 time every 2 weeks depending on assessment of current symptom severity.