Division Criteria for the Certification of Programs through SAPTA per NAC 458

Utilization Management Criteria for Treatment Programs:
Division Criteria adopts ASAM 6 Dimensional Assessment to determine recommendations for initial level of care placement. Division Criteria adopts ASAM Continued Service Criteria, Transfer Criteria and Discharge Criteria for utilization review for ASAM levels of service, non-ASAM or modified-ASAM levels of service and endorsed levels of service, excluding Transitional Housing.

Criteria for Treatment Levels of Service:
Division Criteria adopts The American Society of Addiction Medicine (ASAM) Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (Third Edition, 2013) for the specific program descriptions for the ASAM specific levels of service. The Providers will be required to have policy & procedures (P&P) / program descriptions for each level offered and these will be noted in the P&P section of the certification report.

- **Level 3.5 Clinically Managed Medium-Intensity Residential (Adolescent)**
  - In addition to the description in ASAM, Clinically managed medium intensity residential includes **no less than 25 hours per week of structured interventions.** A minimum of 7 hours of structured activities must be provided on each day. A minimum of 10 hours of clinical counseling services must be provided each week. Types of therapies are noted within ASAM Level 3.5 services.

- **Level 3.5 Clinically Managed High-Intensity Residential (Adult)**
  - In addition to the description in ASAM, Clinically managed high intensity residential includes **no less than 25 hours per week of structured interventions.** A minimum of 7 hours of structured activities must be provided on each day. A minimum of 10 hours of clinical counseling services must be provided each week. Types of therapies are noted within ASAM Level 3.5 services.

- **Withdrawal Management for Level 3.2 WM and Level 3.7 WM only**
  - Required Services in addition to ASAM:
    - During intake, a Blood Alcohol Content (BAC) and/or urine screen will be administered.
    - The person's vital signs must be monitored at least once every 2 hours during the person's waking hours by a staff member with a nursing license, physician license or a SAPTA certified Detoxification Technician.

- **Civil Protective Custody (controlled substance)** (NRS 458.175)
  - Intoxication management for persons taken into Civil Protective Custody (CPC) by a peace officer for being unlawfully under the influence of drugs in a public place, and unable to provide for the health or safety of self or others (NRS 458.175). Civil Protective Custody is not provided in a jail.
  - CPC facility must be a Provider that is SAPTA certified for Withdrawal Management: Level 3.2 WM Clinically Managed Residential Withdrawal Management or Level 3.7 WM Medically Monitored Inpatient Withdrawal Management.
  - Required Services
    - During intake, a Blood Alcohol Content (BAC) and/or urine screen will be administered.

        - The person's vital signs must be monitored at least once every 2 hours during the person's waking hours by a staff member with a nursing license, physician license or be certified as a Detoxification Technician.
    - Upon release from the withdrawal management unit, the person must immediately be remanded to the custody of the apprehending peace officer.

- **Civil Protective Custody (alcohol)** (NRS 458.270)
    - Intoxication management for persons taken into Civil Protective Custody (CPC) by a peace officer for being under the influence of alcohol in a public place, and unable to provide for the health or safety of self or others. Civil Protective Custody is not provided in a jail.
    - CPC facility must be a Provider that is SAPTA certified for Withdrawal Management: Level 3.2 WM Clinically Managed Residential Withdrawal Management or Level 3.7 WM Medically Monitored Inpatient Withdrawal Management.
    - Required Services
        - During intake, a Blood Alcohol Content (BAC) and/or urine screen will be administered.
        - At the earliest practical time the person's family or next of kin must be advised they are in CPC if they can be located.
        - The person's vital signs must be monitored at least once every 2 hours during the person's waking hours by a staff member with a nursing license, physician license or be certified as a Detoxification Technician.
        - Prior to discharge, a good faith effort must be made to advise the person of his/her treatment options.
    - If the person was taken into custody for a public offense, the person must be remanded to the custody of the apprehending peace officer upon release from the withdrawal management unit. (NRS 458.270 (4)).
    - The person may not be required against his or her will to remain in a licensed facility or detention facility longer than 48 hours. (NRS 458.270 (3)).

- **Transitional Housing**
    - Definition: Transitional Housing services consist of a supportive living environment for individuals who are receiving substance abuse treatment in an SAPTA Certified Intensive Outpatient, or Outpatient program and who are without appropriate living alternatives.
    - Admission Criteria:
        - Individuals admitted to Transitional Housing services must be concurrently admitted to a Level 1 Outpatient or Level 2.1 Intensive Outpatient program per an assessment.
        - The ASAM 6 dimensional assessment must be reviewed to ensure there is sufficient risk in Dimension 6: Recovery Environment.
    - Continued Service Criteria:
        - The individual remains in Level 1 or Level 2.1 and ASAM Dimensional reviews reveal continued risk in the Recovery Environment.
        - The individual does not require a higher level of care.
    - Transfer / Discharge Criteria:
        - The individual needs a higher level of care per ASAM Dimensional review and is transferred.
        - The individual has gained stable/supportive housing / recovery environment and no longer needs Transitional Housing.

Service Endorsements:
Providers with Service Endorsements are certified for specific treatment levels of service and receive an endorsement for Co-Occurring Disorder services for Problem Gambling and Substance Use Disorder services.

- **Co-Occurring Disorder Services**
  - The Division adopts the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Rating Scale:
    - The DDCAT rating scale is an evidence-based benchmark instrument for measuring a Provider's capacity to deliver services for persons with co-occurring mental health and substance use disorders. The DDCAT scale is designed to guide both programs and system authorities in assessing and developing dual diagnosis capacity for integrated service delivery.
- **Problem Gambling Services**
  - The Division adopts the Problem Gambling Capability Toolkit (PGCT) Rating Scale:
    - The PGCT rating scale is based on an evidence-based benchmark instrument for measuring a Provider's capacity to deliver services for persons with co-occurring problem gambling and substance use disorders. The PGCT scale is designed to guide both programs and system authorities in assessing and developing dual diagnosis capacity for integrated service delivery.

Other Division Services:
The Providers will be required to have policy & procedures and program descriptions for each level offered and these will be noted in the P&P section of the certification report.

- **Drug Court Service**
  - The Division Criteria for Drug Court Programs is in compliance with all applicable provisions of NAC 458.
- **Evaluation Center**
  - The Division Criteria for Evaluation Centers is in compliance with all applicable provisions of NAC 458. Programs will determine whether a person is appropriate for treatment per the ASAM Criteria.
- **Information and Referral Services**
  - The Division Criteria for Informational and Referral Services is in compliance with all applicable provisions of NAC 458.
- **Coalition Programs**
  - The Division Criteria for Coalition Programs is in compliance with all applicable provisions of NAC 458.
- **Administrative Programs**
  - The Division Criteria for Administrative Programs is in compliance with all applicable provisions of NAC 458.
- **Prevention Programs**
  - The Division Criteria for Prevention Programs is in compliance with all applicable provisions of NAC 458.

Division Criteria for Certified Treatment Programs
Treatment of Clients with an Opioid Use Disorder

Certified treatment programs, private, public or funded cannot deny treatment services to clients that are on stable medication maintenance for the treatment of an opioid use disorder including FDA approved medications.

Division Criteria for Certified Treatment Programs
Treatment Episode Data Set (TEDS)

Certified treatment programs, private, public or funded are required to report Treatment Episode Data Set (TEDS) to SAPTA on a monthly basis in a format determined by the Division.

Division Criteria for the Certification of
Medication Assisted Treatment Centers

Integrated Opioid Treatment and Recovery Center's (IOTRC's)

There are two options for certification under this designation: The Provider can only be certified for one of the two options.

Option 1:

- Opioid Treatment Program (OTP): Licensed by the Division through Health Care Quality & Compliance (HCQC) (Narcotic Treatment Center/NTC) and Certified by the Division through the Substance Abuse Prevention and Treatment Agency (SAPTA)
    - This level of service, shall utilize Methadone and other FDA approved medications for the treatment of an opioid use disorder.
    - In addition, the Provider shall meet all applicable requirements of NAC 458 including Division Criteria approved by the Commission on Behavioral Health.
    - Programs under Option 1 shall admit patients within 48 hours of referral.

Option 2:

- Medication Assisted Treatment (MAT) Program
    - This level of service shall utilize at a minimum two (2) of the three (3) FDA approved medications for an Opioid Use Disorder.
    - The Provider shall also have a formal written care coordination plan with an Opioid Treatment Program that utilizes Methadone.
    - In addition, the Provider shall meet all applicable requirements of NAC 458 including Division Criteria approved by the Commission on Behavioral Health.
    - Programs under Option 2 shall admit patients within 48 hours of referral

Programs certified under Option 1 or Option 2 must also provide the following services and meet all applicable requirements.

- Shall meet the requirements of NAC 458 and applicable Division Criteria requirements for Co-occurring Disorder endorsement.
- Shall meet the requirements of NAC 458 and applicable Division Criteria requirements for Level 1 Outpatient services.

- Shall meet the requirements of NAC 458 and applicable Division Criteria requirements for Level 1 Ambulatory Withdrawal Management services.
- The prescriber shall conduct an intake examination that includes any relevant physical and laboratory tests including random monthly toxicology of clients on MAT.
- Shall conduct a written medical evaluation for clients prior to commencing Medication Assisted Treatment (MAT).
- Shall provide onsite or through referral HIV/Hepatitis C testing.
- Shall provide overdose education and Naloxone distribution.
- Additionally, coordination of services with other providers shall include a formal written agreement stating the clear referral path, communication related to patient care and documentation of coordination in the clinical record.
- Shall provide dedicated Care Coordination services.
- Shall provide Mobile Outreach Recovery services.
- Shall provide Supported Employment services onsite or through referral.
- Shall provide dedicated Peer/Recovery Support Services billable under Medicaid to the extent possible. If the Provider is not currently enrolled in Medicaid, the Provider will proceed with this process and agree to bill Medicaid for such services once enrolled.
- Peer/Recovery Support Services shall include evidence based practices and meet all Medicaid billing requirements for such services.
- Shall provide 24 hours, 7 days a week, 365 days a year emergency telephone system for patients.
- Shall develop a written formal policy related to medication monitoring and diversion. This policy will follow the Drug Enforcement Administration (DEA) to ensure the protocol is being followed.
- Shall develop a written formal policy related to Pregnant Women receiving medication assisted treatment including, but not limited to:
    - Shall provide onsite or through referral Obstetrician/Perinatologist services.
    - Due to the risks of opioid addiction to pregnant women and their fetuses, a pregnant woman seeking buprenorphine from a certified provider shall either be admitted to the program or referred to an OTP within 48 hours of initial contact.
    - Prescribers unable to admit pregnant women, or unable to otherwise arrange for MAT care within 48 hours, shall notify SAPTA within 48 hours to ensure continuity of care.
    - In the event that a pregnant woman is involuntarily withdrawn from MAT, the prescriber shall refer the woman to a high-risk obstetrician (OB) physician for care. If no high-risk OB is available, the woman can see a local obstetrician who prescribes buprenorphine until a high-risk OB is available.
- Shall provide services within a multidisciplinary team approach and at a minimum require the following multidisciplinary team members:
    - Nevada Licensed Physician and/or Physician Assistant or nurse Practitioner who has been approved by the FDA Waiver to prescribe buprenorphine and buprenorphine/naloxone.
    - Skilled nursing staff licensed by the State of Nevada.
    - Nevada Licensed Alcohol and Drug Counselor or Licensed Clinical Alcohol and Drug Counselor and Certified Alcohol and Drug Counselor.
    - Nevada Licensed Clinical Social Worker, Licensed Psychologist, Licensed Marriage and Family Therapist, or a Licensed Professional Counselor.
    - Medicaid approved Case Manager (Qualified Mental Health Professional/QMHP or/a Qualified Mental Health Associate/QMHA).
    - Peer Support Specialist.

- Shall provide at a minimum the following Evidence Based Practices (EBP's) recommended in the ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use publication, (2015).
    - Cognitive Behavioral Therapy
    - Behavioral Couples Counseling when clinically indicated
    - Cognitive Behavioral Coping Skills
    - Community Reinforcement Approaches
    - Motivational Enhancement
    - Relapse Prevention
- Shall have an Emergency and Closure Preparedness Plan
    - Each certified program shall develop and maintain a plan for the administration of medications in the event of a temporary closure due to inclement weather, prescriber illness or similar unanticipated service interruptions. The plan shall include:
        - A plan for a reliable mechanism to inform patients of these emergency arrangements.
        - The identification of emergency procedures for obtaining prescriptions/access to medications in case of temporary program/office closure. This may include an agreement with another physician authorized to prescribe buprenorphine and buprenorphine/naloxone, an OTP or another FDA approved prescriber.
    - Each certified program shall have a plan for continuity of care in the event that a future voluntary or involuntary program closure occurs. Programs shall have an operational plan for managing a program closure. The plan shall include:
        - The orderly and timely transfer of patients to another Office-based Opioid Treatment (OBOT) Provider.
        - Notification to patients of any upcoming closure and reassure them of transition plans for continuity of care.
        - Notification to SAPTA no fewer than 60 days prior to closure to discuss the rationale for closure, and plans for continuity of care.
        - A plan for the transfer of patient records to another Provider.
        - A plan to ensure that patient records are secured and maintained in accordance with State and Federal regulations.
- Shall meet the minimum standards per to NAC 458 and Division Criteria related to assessment of the client's needs. In addition, the program shall provide a comprehensive evaluation that includes the following requirements;
    - behavioral health history (including trauma history);
    - a diagnostic assessment, including current mental status;
    - assessment of imminent risk (including suicide risk, danger to self or others, urgent or critical medical conditions, other immediate risks including threats from another person);
    - basic competency/cognitive impairment screening (including the consumer's ability to understand and participate in their own care);
    - a description of attitudes and behaviors, (including cultural and environmental factors, that may affect the consumer's treatment plan);
    - assessment of need for other services related to Limited English Proficiency (LEP) or linguistic services;
    - assessment of the social service needs of the consumer, with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate.

Division Criteria for the Certification of Hospital-based ASAM Level 3.7 and Level 4 Programs through SAPTA per NAC 458

Criteria for ASAM Level 3.7 and Level 4 Treatment Service:
Division Criteria adopts The Joint Commission accreditation for hospitals. The Providers will be required to submit their Joint Commission report with any quality improvement requirements along with their application for Certification.

Division Criteria for the Certification of Substance Use Prevention Coalitions through SAPTA per NAC 458

Substance Use Disorder (SUD) Prevention Coalitions

- The Division Criteria for SUD Prevention Coalitions is in compliance with all applicable provisions of NAC 458, and NRS 458 as amended by SB 69 (2021).
    - Whenever possible, Division Criteria will avoid the use of stigmatizing language in describing substance use.
    - Division Criteria recognizes diversity, equity and inclusion is necessary to improve the health and wellness of the community and strives for cultural competency.

- The Division of Public and Behavioral Health adopts the Community Anti-Drug Coalitions of America (CADCA) National Coalition Institute Community Coalitions Model. The operation of a certified SUD Prevention Coalition must align with these nationally recognized standards, as outlined in the Drug-Free Communities Act of 1997.
    - SUD Prevention Coalitions shall include substance misuse and substance use disorder prevention as an area of focus to improve the health and wellness of the general community.
    - SUD Prevention Coalitions shall demonstrate that the representatives of the coalition have worked together on substance use reduction initiatives for a period of not less than 6 months as demonstrated by meeting minutes.
    - SUD Prevention Coalitions develop and implement strategies and programs based on CADCA's Seven Strategies for Creating Effective Community Change and/or the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse and Prevention (CSAP) prevention strategies.
    - SUD Prevention Coalitions award funding to certified prevention programs and provide oversight to their activities.

- Each certified SUD Prevention Coalition must designate every region that they plan to serve. The geographic regions, are described in NRS 433.428 as follows:
    - The Northern Behavioral Health Region consisting of Carson City, and the counties of Churchill, Douglas, Lyon and Storey;
    - The Washoe Behavioral Health Region consisting of Washoe;
    - The Rural Behavioral Health Region consisting of the counties of Elko, White Pine, Eureka, Humboldt, Lander and Pershing.
    - The Southern Behavioral Health Region consisting of the counties of Esmeralda, Lincoln, Mineral and the portion of the county of Nye that is north of the 38th parallel of north latitude; and

- The Clark Behavioral Health Region consisting of the county of Clark and the portion of the county of Nye that is south of the 38th parallel of north latitude; and

- Each geographic region may be served by more than one SUD Prevention Coalition.
  - When a geographic region is served by more than one coalition, the coalitions may choose to join the report of other coalitions or choose to submit separate reports for the same area.
  - A certified SUD Prevention Coalition should collaborate with the community, the Division of Public and Behavioral Health and applicable Regional Behavioral Health Policy Board to ensure that the primary purpose of any report is to identify trends and strategies to address the needs of the community.
  - A certified SUD Prevention Coalition will make any report to a Regional Behavioral Health Policy Board available and accessible to the community and the Division of Public and Behavioral Health.

- A certified SUD Prevention Coalition must develop a membership process that includes:
  - A process to convene interested persons and entities to promote the use of evidence-based strategies to address needs concerning services for the prevention of substance misuse and substance use disorders and improve such services in the geographic region(s) serviced by the SUD Prevention Coalition.
  - A request for information related to the interested person's race, ethnicity, sexual orientation and gender identity or expression. No person is required to provide any information or be denied membership or any services or assistance based on their response or declination to respond. The information may only be used to carry out and improve the services of the coalition and for demographic analysis by the Division
  - The membership categories of representation should address the needs of the community based on an assessment of the geographic region(s) served by the SUD Prevention Coalition and include, at a minimum, representation as defined in the twelve sectors of the Drug-Free Communities Act of 1997 as follows:
    - Youth;
    - Parents;
    - Businesses;
    - Media;
    - Schools;
    - Organizations serving youth;
    - Law enforcement;
    - Religious or fraternal organizations;
    - Civic and volunteer groups;
    - Health care professionals;
    - State, local or tribal governmental agencies with expertise in the field of substance abuse (including, if applicable, the State authority with primary authority for substance abuse);
    - Other organizations involved in reducing substance abuse; and
    - When feasible, elected officials should be encouraged to participate.

- As described in NRS 458, a certified substance SUD prevention coalition shall:
  - Advise the Department of Health and Human Services and the Division of Public and Behavioral Health concerning:

        - The needs of adults and children in the geographic region served by the prevention coalition concerning the prevention of substance misuse and substance use disorders in the geographic region;
        - Any progress, problems or plans relating to the provision of services for the prevention of substance misuse and substance use disorders and methods for improving the provision of such services in the geographic region served by the prevention coalition;
        - Identified gaps in services for the prevention of substance misuse and substance use disorders and recommendations for addressing those gaps; and
        - Priorities for allocating resources to support and develop services for the prevention of substance misuse and substance use disorders in the geographic region served by the coalition.
    - Coordinate and share information with other certified substance use disorder prevention coalitions and the general community to provide recommendations to the Department of Health and Human Services and the Division of Public and Behavioral Health concerning services for the prevention of substance misuse and substance use disorders.
    - Implement, in coordination with the Department of Health and Human Services, the Division of Public and Behavioral Health, other certified substance use disorder prevention coalitions and other interested persons and entities, statewide efforts for the prevention of substance misuse and substance use disorders.
    - Coordinate with persons and entities in this State who provide services related to the prevention of substance misuse and substance use disorders to increase the awareness of such services and reduce duplication of efforts.
    - In consultation with other persons and entities in this State who provide services related to the prevention of substance use disorders, submit an annual report to the regional behavioral health policy board for the geographic region served by the substance use disorder prevention coalition. The report must include, without limitation:
        - Identification of the specific needs of the geographic region served by the prevention coalition concerning the prevention of substance misuse and substance use disorders;
        - A description of methods that the coalition uses to collect and analyze data concerning:
        - Substance misuse and substance use disorders in the geographic region served by the coalition; and
        - Gaps in services related to the prevention of substance misuse and substance use disorders and the need for additional services in that region;
        - The goals and strategies used by the prevention coalition and the results of those strategies;
        - The goals of the prevention coalition for the immediately preceding year and the degree to which the prevention coalition achieved those goals; and
        - The goals of the prevention coalition for the immediately following year and the long-term goals of the prevention coalition.

- As set forth in NRS 458, the Division of Public and Behavioral Health shall collaborate with and utilize certified substance use disorder prevention coalitions as the primary local and regional entities to coordinate programs and strategies for the prevention of substance use disorders in this State.

Division Criteria for the Certification of Recovery Housing

Criteria for Recovery Housing Services:

- Division Criteria adopts the National Alliance for Recovery Residence (NARR) Standard 3.0, which has been adapted in Nevada for certification of Recovery Housing.

- The Division Criteria for Recovery Housing is in compliance with all applicable provisions of NAC 458.

- Recovery Housing must also be licensed as a Halfway House for Recovering Alcohol and Drug Abusers under NAC 449.1549-449.154945.

  - **Definition:**
    - The term "recovery residence" (Recovery Housing in the State of Nevada) denotes safe, substance free and healthy residential environments in which skills vital for sustaining recovery are learned and practiced in a home-like setting, based on Social Model principles.
  - **Eligibility Criteria:**
    - History of substance use treatment or participation in 12-Step Recovery.
    - Individual will sign a client-contract indicating adherence to Recovery Housing rules and be free from alcohol or illicit substance use or seeking.
    - Adhere to random drug screening and/or toxicology screening.
  - **Admission Criteria:**
    - Individuals admitted to Recovery Housing Services must have a history of a Substance Use Diagnosis.
  - **Continued Service Criteria:**
    - The individual does not require a higher level of care. The Recovery Housing program will need to develop criteria to determine on-going service need.
  - **Transfer / Discharge Criteria:**
    - The individual has gained stable/supportive housing/recovery environment and no longer needs Recovery Housing.

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.