1. ACT Continuity of Care for Incarcerated Member’s
2. ACT Crisis Involvement
3. ACT Home Visits
4. ACT Inpatient / Discharge Planning
5. Monitoring Assertive Community Treatment Outcomes
6. ACT Program Organization and Communication
7. ACT Referral Process
8. ACT Self Administration of Medication
9. ACT Service Intensity and Capacity
10. ACT Substance Abuse Treatment

Attachment included:

1. ACT Admission Screening Criteria Checklist
2. ACT Key Terms
Cross Reference(s)
NAMI National ACT Standards, SAMHSA, CARF Program Standards; CO.238.01DCC. Continuity of Care for Incarcerated Members

Purpose
This operating protocol describes the process of providing information regarding visitation, reviewing the Individual Service Plan (ISP) and follow-up upon release in order to maximize coordination of behavioral health treatment for members who become incarcerated. This protocol also establishes coordination process for incarcerated members.

Standards
I. Requirements for visiting an incarcerated member.

A. ACT team shall visit members who are incarcerated within 72 hours of notification of incarceration at the Maricopa County Jail.

B. During this visit, the ACT staff shall make efforts to obtain the member’s consent to release information to the Maricopa County Jail’s office staff necessary to develop an adequate discharge treatment plan upon release from the jail.

C. If a member is receiving psychiatric treatment from the jail, including medications; the clinical team may release only that information necessary to provide psychiatric treatment to jail staff without the member’s consent as set forth in agency policies regarding confidentiality.

D. The ACT team shall obtain jail inpatient staffing dates and shall ensure that a member of the clinical team attends the staffing(s) telephonically or in person to assist in the coordination of care and services.

E. A member of the ACT team shall make a minimum of weekly visits or as frequently as determined necessary by the clinical team during the member’s period of incarceration.

F. Staff visiting a member shall adhere to their agency’s Code of Ethical Conduct Policy

II. Review and Update of the ISP

A. Within 24 hours of notification of incarceration, the ACT team shall review, and update as needed, the ISP and identify services the member will need at the time of release.

B. The plan for services to be provided at the time of release from jail shall be outlined on a progress note in the electronic medical record system. The ISP shall be updated to reflect the discharge plan. The plan shall include recommendations from the member, clinical team, jail staff and the Court Liaison, and shall address the following:

   a. Living arrangements;
   b. Transportation from jail upon release;
   c. Basic needs;
   d. Psychiatric needs;
   e. Medical care, and
   f. Legal issues/concerns.
C. The ACT team shall plan and prepare to deliver services as outlined in the plan immediately upon development, to include referrals for a variety of services (e.g. co-occurring residential programs, outpatient substance abuse programs) as identified by jail health staff and/or the court liaison.

D. ACT team shall not discuss the actual legal case with the member, and shall refer the member to his or her assigned attorney for all legal discussions.

E. The Court Liaison shall be contacted after the initial visit to discuss treatment options.

F. RBHA Court Advocacy and Mental Health Jail Diversion Team and/or APNO court liaison shall work within the jail and court systems to actively promote the concept of jail diversion to community based treatment for incarcerated member.

G. ACT team staff may be contacted by the court liaison and/or the Department of Court Advocacy and Mental Health Jail Diversion Team staff prior to the member’s court appearance to discuss the appropriateness of community-based alternatives to incarceration.

H. The court liaison and/or the Department of Advocacy and Mental Health Jail Diversion Team staff may appear at Court to present treatment options or provide assistance as determined necessary.

I. ACT team staff shall appear with the court liaison at Mental Health Court for respective members. ACT team staff is required to attend both the pre-hearing staffing and the actual hearing that follows.

III. Clinical Team Follow-Up upon Release

The member should be seen by the outpatient provider within 24 hours of release from jail. During this visit, the member should be assessed to ensure all needs are met in accordance with the treatment plan.

A. The clinical team shall provide services to the members in accordance with updated service plan in order to ensure, promote, and/or maintain the members:
   1. Safety;
   2. Security;
   3. Symptom reduction;
   4. Physical health; and
   5. Recovery and rehabilitation.

IV. Release Information

A. Upon notification, members released Monday through Friday are to be picked up by an ACT team member. A hold may be requested for any member in general population for release to an ACT team member.
B. Inpatient Psychiatric Release
   1. Upon notification, members released from LBJ IP Psych Unit are to be picked up by an ACT team member. These releases are to be treated as a hospital release;
   2. A staffing scheduled by the jail counselor and ACT team member shall be held prior to discharge during which time the member’s discharge plan is reviewed;
   3. The At Risk Crisis Plan (ARCP) shall be updated;
   4. The ACT team shall provide transportation from the jail facility to their home;
   5. The ACT team will assist the member in obtaining medications in accordance with the discharge plan upon discharge from the inpatient facility;
   6. Members shall be seen by a BHMP at the clinic the same day of release (or next business day, if released on a Saturday or Sunday. The following documents will be obtained from the jail facility and provided to the BHMP prior to the scheduled appointment:
      a. Copy of the Psychiatric Admission Initial Evaluation.
      b. Copy of the Medical Physical Examination.
      c. Copy of most recent laboratory results from the inpatient facility.
      d. List of final discharge medications provided by the inpatient facility.
      e. Copy of any medical consultations provided during the hospitalization from the inpatient facility.
   7. A member of the ACT team shall maintain daily face-to-face contact with the member during the first 5 days (including weekends) following discharge. A minimum of 3 of the face-to-face contacts must occur at the member’s place of residency.
   8. The ACT team will ensure the person’s AHCCCS provider or other primary care provider is notified of the person’s inpatient admission in accordance with the Primary Care Physician Coordination and Continuity of Care policy.
   9. For persons considered to be at-risk for re-arrest, the ACT team will meet weekly to discuss the person’s progress toward the goals identified in the ISP. Members incarcerated at LBJ IP Psych Unit can be held for 24 hours to ensure a PNO pick-up.

C. General Population Release: members who are released from general population need to be seen by a BHMP at the clinic within 72 hours of release, even if the incarceration period was brief.

D. Weekend Release: Upon notification, arrangements for transportation and medications must be made for weekend releases. A progress note must be entered with the discharge plan clearly stated, especially including the destination address, a contact person and phone number. The on call ACT team member should be consulted for weekend releases.
Purpose

Establish the Assertive Community Treatment team’s role when a member is experiencing a crisis. An immediate response can help minimize distress when persons with severe mental illness are faced with crisis. When the ACT team provides crisis intervention, continuity of care is maintained.

Standards

I. ACT teams are responsible for providing crisis assessment and intervention 24 hours a day, seven days a week.
   A. ACT staff shall serve as the primary responder to ACT member crisis calls.
   
   B. ACT staff shall be scheduled to provide crisis services during all after hours, weekends, and holidays.
   
   C. There shall always be one ACT staff member on-call and at least one back-up ACT staff on-call to support the primary on-call.
   
   D. The ACT team leader shall always be available for crisis consultation, or shall designate an alternative clinical supervisor to support the ACT staff on-call.
   
   E. The primary on-call shall be responsible for the designated on-call phone. All scheduled on-call ACT staff shall respond immediately to all crisis calls directed to their phones. If a call is missed, on-call ACT Staff shall return the call within 15 minutes. (Phones must remain charged, functioning, and accessible.)

II. ACT Risk Crisis Plans
   A. ACT team leader to ensure that each member has a current At Risk Crisis Plan and that it includes the following information:
      i. First line of ARCP shall identify the member as an ACT member and shall list the on-call telephone number and a back-up telephone number (ACT team leader’s telephone number);
      ii. The second sentence shall direct MCRN staff to immediately contact the ACT Team unless the member is determined to require immediate medical intervention;
      iii. Current status (mental health, psychosocial issues, legal issues);
      iv. Description of what the member is like when feeling well;
      v. Adherence with treatment (medication adherence, attends appointments, etc);
      vi. Current living situation (include supports, family friends, residential staff, where they live, who they live with, include names and telephone numbers);
      vii. Major medical problems (any medical medications);
iii. Crisis interventions occur telephonically and face-to-face
   A. Members are instructed to call the ACT team 24 hour on-call staff when requesting assistance with a crisis.

   B. If an ACT member contacts MCRN they will immediately contact and connect the ACT member to the respective ACT team’s on-call staff.

   C. Upon receipt of the crisis call ACT staff will assume responsibility for the call and will direct the crisis intervention.

   D. If crisis resolution is achieved on the telephone the ACT on-call staff shall:
      i. Document the nature of the crisis call and the resolution;
      ii. Present and review the crisis encounter in the next daily team meeting with a focus on developing strategies to pre-empt future crisis; and
      iii. Strategies shall be implemented and tracked in the daily team meeting log.

   E. If crisis resolution is not achieved via telephone then a face-to-face intervention shall be initiated.
      i. The ACT on-call shall consult with the ACT team leader and determine a plan of action before going out into the field. Safety of the staff members and members will be the first priority.
      ii. ACT team leader may seek further consultation from the site clinical director, contact the ACT psychiatrist (as a back-up to the ACT psychiatrist the doctor on-call for the direct care clinics), engage MCRN and request a mobile team, and/or involve the police department.
      iii. If a mobile team and/or police are dispatched the on-call must meet the team at the scene and actively participate in the intervention.
      iv. ACT on-call shall check back in with the ACT team leader at a pre-determined time or after the face-to-face intervention is completed for safety reasons and to debrief.
         1. If the ACT on-call fails to call the ACT team leader at the designated time the ACT team leader will initiate phone contact with the on-call staff and if contact is not obtained the ACT team leader may coordinate a wellness check with the police department.

   F. If crisis resolution is achieved at the face-to-face encounter the ACT on-call staff:
      i. Document the nature of the crisis call and the resolution;
      ii. Present and review the crisis encounter in the next daily team meeting with a focus on developing strategies to pre-empt future crisis; and
iii. Strategies shall be implemented and tracked in the daily team meeting log.

IV. Transportation to a psychiatric urgent care center or to a medical emergency room.
   A. The ACT on-call shall consult with the ACT clinical coordinator and mutually agree on a plan of action before transporting a service recipient. Safety of the staff members and members will be the first priority.
   B. To promote safety the ACT teams may utilize mobile teams, ambulances, and the police departments to transport members.

V. PRN medications
   A. If the BHMP authorizes PRN medications the member is instructed to call the ACT team 24 hour on call staff member or MCRN when requesting a PRN medication for alleviating their behavioral health symptoms.
   B. The on call staff will call the on call BHMP for their assigned network. If the BHMP authorizes PRN medications on a short term basis, the on call staff member will take the member to the pharmacy for the supply of PRN medication.
   C. If PRN medication is authorized, the staff member will document the PRN medication on the observation of self-administration of medication log after observation of taking the PRN medication. The medication order should be documented on the medication flow sheet and filed in the member’s medical record.
   D. If warranted, the BHMP may complete crisis intervention with the member over the phone and determine if the member needs a higher level of care and should be transported to the psychiatric urgent care center or emergency room.
Purpose

An ACT team provides services in the community. The majority of treatment and rehabilitation interventions take place “in the community,” (SAMHSA guidelines >80% of service delivery); a high number of these community visits occur in a recipients own place of residence. The ACT program works to monitor status, develop community living skills in the community verses traditional office based services. This protocol will serve to describe the key elements of a home visit and promotion of safety of ACT staff during visits.

Standards

I. Frequency of home-visits:
   A. The frequency of home-visits shall be based upon the individual needs of the members; minimally ACT members shall receive one home visit every 14 days.

   B. ACT provides 80% of service encounters in the community in non-office-based or non-facility-based settings. A home-visit is considered a community visit.

II. The purpose of the home visit is assessing of the members current ability to meet their basic needs. The home visit is also an opportunity to determine the level of assistance necessary to support, provide resources so that the members can obtain activities of daily living (ADL) and enhance housing permanency. The ACT team shall directly provide services to support and provide education to the member on ADL’s in the home environment. ACT staff shall also conduct an assessment of the quality of the living environment at each home visit to ensure that there are no obvious hazards, all utilities are working, and there are no risks to losing housing. In regards to housing support, the ACT team acts as a supported housing provider and is expected to follow supportive housing SAMSHA guidelines including emphasis on all 7 fidelity dimensions adherence.

   A. Under the following circumstances the ACT staff shall take immediate action to address the following unsafe living situations:
      i. Residence does not have running water;
      ii. During “excessive heat days” the air conditioner is not working; and,
      iii. Any other hazards that have a reasonable potential to place the members at significant risk if not immediately addressed.

   B. Immediate action must either resolve the critical issue or provide the members with an alternative living arrangement until the critical circumstance is resolved. Following are interventions that the ACT Team may utilize:
      i. Placement in alternative housing until the unsafe living situation is resolved;
      ii. Utilization of community resources to make repairs or reconnect utilities,
      iii. Flex funds; and/or,
      iv. Assisting the members with relocating to a new residence.

   C. The ACT team shall formally consider initiating an emergent or non-emergent petition/amendment in the circumstance that the team determines that a members living arrangement is unsafe and the member refuses to address the critical issue. The team should review concerns with the BHMP and if necessary screen for COE.
III. Staff personal safety when completing a home visit should include the following:
   A. Always try to maintain personal space of 3 feet.
   B. No touching of any kind should occur.
   C. Staff members shall remain current on Crisis Prevention/Intervention safety techniques. This class is required every 2 years.
   D. Be aware of surroundings at all times. If there is a potentially dangerous situation, the staff member should be accompanied by another staff member or illicit the help of local law enforcement. If a staff member begins to feel threatened, he/she shall leave.
   E. The meeting should be brief, and the staff member shall avoid taking unnecessary risks. If the member appears to possess a weapon or an object that could be used as a weapon, the visit shall be terminated and call the proper law enforcement authority immediately.
   F. If it is necessary to terminate a home visit or leave the recipients home out of concern for safety, contact a supervisor immediately. It is expected that the member of the clinical team follows their APNO policy on safety during home visits or visits in the community.
Purpose

To establish key elements and case management responsibilities in:

1. The review of medical necessity criteria for psychiatric inpatient admissions;
2. The development of an inpatient discharge plan;
3. The requirements for completing hospital discharge plans;
4. The revision of a person’s individual service plan (ISP);
5. The review of discharge requirements from an inpatient facility; and
6. The review/modification of the person’s treatment plan, within 7 days of discharge from, or upon readmission, to an inpatient facility.

Standards

A. Admission Criteria to Psychiatric Acute Hospital or Sub-Acute Facility (A person must meet ALL criteria in Sections A., C., and D., and at least ONE of the criteria in Section B)

   A. Behavior and Functioning
      i. Imminent risk of danger to self or others as a result of a behavioral health condition as evidenced by:
         1. Current suicidal ideation, behavior or intent;
         2. Current homicidal ideation, behavior or intent;
         3. Significant ideation to assault, behavior or intent; or
         4. Immediate physiologic jeopardy.
      ii. Disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation;
      iii. Disturbance of mood, thought or behavior that requires an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting; or
      iv. Level of functioning that does not meet the above criteria, but less restrictive levels of care suitable to the meet the members needs are unavailable or the person cannot return to his or her residence due to risk of harm to self or others due to a treatable behavioral health disorder, or there is a likelihood of imminent behavioral de-compensation.

   B. Intensity of Service
      This type of service provides planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. Treatment should be in the least restrictive type of service consistent with the person’s need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in a less restrictive type of service.

   C. Expected Response
      The member’s behaviors and symptoms, which were identified as reasons for admission, can be effectively treated by medically indicated treatment available in this inpatient setting. The treatment can reasonably be expected to improve or stabilize the member’s condition so that this type of service will no longer be needed.
B. Development of the Inpatient Discharge Plan:
   A. The ACT team will begin planning for a person’s discharge as soon as the team
      determines inpatient psychiatric treatment is required.
   B. The discharge plan involves:
      i. Reviewing events that occurred prior to the person’s inpatient admission to
determine if there were early warning signs indicating the person was displaying
increased need. Common early warning signs can include:
         1. An increase in mental health symptoms;
         2. Refusal to participate in some or all of the interventions outlined in their
treatment plan;
         3. Refusal to take some or all prescribed medications;
         4. Missing or not showing up for scheduled appointments with any
member of the treatment team;
         5. Decrease in hygiene or personal care;
         6. An increase in isolation or isolative behaviors;
         7. Refusal to participate in activities previously of interest; or
         8. Increased substance use.
      ii. Engaging the person and other involved parties in discussions about the
importance of identifying and recognizing early warning signs as a method to
avoid increased symptoms requiring higher levels of care and treatment.
      iii. Discussing and planning interventions, services and/or supports that will be
required to assist the person in maintaining the level of stability obtained
through inpatient psychiatric treatment.

C. ACT Team’s Responsibilities for Discharge Planning
   A. Within 24 hours following an inpatient psychiatric admission or a clinic assignment after
new SMI determination, the following must occur:
      i. The clinical team’s Behavioral Health Medical Practitioner (BHMP) will contact
the inpatient treatment prescriber to discuss:
         1. The reason for the person’s admission;
         2. The person’s current symptoms;
         3. Past and current treatment received by the person; and
      ii. The outpatient BHMP will be responsible for initiating and completing a weekly
consultation with the inpatient BHMP. The consultation will include clinical
updates and review of the hospital discharge plan. The information from these
consultations will be communicated to the clinical team at the next ACT daily
staff meeting.
      iii. The person will be reviewed and tracked in the morning meeting, per the
morning meeting workflow and procedures document, on a daily basis
throughout the entire inpatient hospitalization and at least 5 working days
following discharge for 5 day follow up/4 week post discharge follow up. On an
ACT team, a person is reviewed daily regardless of IP utilization.
iv. The ACT Clinical coordinator or designee will contact the inpatient social worker to begin discussion of a plan for treatment upon discharge (discharge plan) and to schedule a date within 72 hours for an initial staffing to be held at the inpatient facility. Thereafter, staffings should occur weekly and within 24 hours of discharge.

v. ACT staff shall maintain contact with the inpatient social worker every 72 hours at minimum throughout the duration of the person’s inpatient hospitalization to monitor the member’s current status, discharge plan, and readiness for discharge. Contact may be established via email providing precautions have been implemented to maintain the security of protected health information (i.e. encryption, SIGABA account, password protected).

vi. ACT team staff will conduct a hospital visit to meet face-to-face with the member every 72 hours (to include weekends).

vii. ACT team to attend all inpatient staffings while the member is in an inpatient setting.

B. Within 72 hours of admission, the ACT team will visit the member at the inpatient facility and conduct a staffing with the inpatient clinical team. During this meeting, the following with occur:

A. Provide a copy of the person’s Individual Service Plan to the inpatient clinical team.

B. Discuss the plans for discharge with the person based on his/her presenting symptoms at the time of admission and his/her anticipated needs at the time of discharge; and

C. Document the contact with the person on a progress note provided by the inpatient facility and have it filed in the person’s inpatient medical record. This contact will also need to be documented at the direct care clinic (DCC) in the medical record.

D. Reconciliation of the initial hospital discharge plan developed by the outpatient and inpatient clinical teams.

i. The inpatient clinical team will utilize the Inpatient Treatment and Discharge form (ITDP) to document the hospital discharge plan. The ITDP is a living document that must be updated weekly or as needed to reflect any changes to the hospital discharge plan.

ii. The CD at the DCC and the Care Management Department at the RBHA will both be responsible for ensuring the ROP and ITDP are consistent and updated weekly or as needed.

iii. Any disagreements between the outpatient and inpatient clinical teams that cannot be resolved should be presented to the appropriate Medical Director for final resolution.

I. If the person remains hospitalized for 7 days or longer, the CD will ensure a copy of the Inpatient Treatment and Discharge Plan (ITDP) is be obtained by the 10th day and placed in the person’s medical record.

II. ACT staff obtains the documentation outlined below under Section V. E before the scheduled appointment with the BHMP.
III. The clinical team shall never consider referral of the person from an inpatient setting to a Supervisory Care/Board and Care Home (SCH/BCH) as a suitable plan for discharge.
   A. The person, clinical team and inpatient team must evaluate the person’s anticipated treatment needs upon discharge from the inpatient facility and make referrals to appropriate treatment providers immediately. If a recommended covered service is unavailable, the Clinical Director or designee will enter the need in the unmet needs data base.
   B. If the person was residing in a SCH/BCH prior to inpatient admission, the clinical team and inpatient team must make efforts to assist the person in locating and obtaining alternative housing options in effort prevent the person’s return to SCH/BCH.
   C. No person shall ever be discharged from an Inpatient Level I Acute facility to a Halfway House, without approval from the Site Clinical Director.
   D. No person shall ever be discharged from an Inpatient Level I Acute facility to a shelter without prior approval from the site Clinical Director.

IV. Completing the Hospital Discharge Plan Process
   A. If the person remains in an inpatient setting for three days or longer, the clinical team and inpatient psychiatric team will assist the person to develop a Hospital Discharge Plan that will be incorporated in the person’s Individual Service Plan (ISP) based on the ITDP.
   B. The hospital discharge planning process will include an appropriate disposition, significant supports, and goals to help the individual remain out of the hospital.
   C. The ACT team will revise the treatment plan and will incorporate recommendations from members of both the inpatient and outpatient clinical teams, family members, and provider agencies currently involved in providing care to the person.
   D. It is the responsibility of the ACT team to ensure the completion of any revisions to the person’s ISP within 7 days of discharge from an inpatient facility.
   E. The person and clinical team must sign the revised ISP and give a copy to the person.
   F. If the person is court-ordered to receive treatment at the time of discharge, in addition to the Hospital Discharge Plan the ACT team will work with the person to develop the person’s Special Treatment Plan (STP) within 72 hours of discharge.

V. Requirements for Discharge from an Inpatient Facility
   A. A staffing scheduled by the inpatient social worker and ACT Clinical coordinator shall be held prior to discharge during which time the person and all members of the clinical team will review the Hospital Discharge Plan.
   B. Prescriptions (and any related prior authorizations) need to be obtained for a minimum of a 7 day supply for all Discharge Medication. The At Risk Crisis Plan (ARCP) shall be updated to incorporate information included in the Hospital Discharge Plan, as appropriate.
C. The ACT team will ensure the person has adequate transportation from the inpatient facility to their home. If a person is being discharged from a Level I Sub-Acute facility during business hours the ACT team should provide transportation.

D. The ACT team will assist the person in obtaining medications in accordance with the discharge plan upon discharge from the inpatient facility.

E. Within 72 hours of discharge, the person will be evaluated at the assigned clinic by the BHMP. The following documents will be obtained from the inpatient facility and provided to the BHMP prior to the scheduled appointment:
   i. Hospital’s final discharge plan or ITDP.
   ii. Copy of the psychiatric admission initial evaluation.
   iii. Copy of the medical physical examination.
   iv. Copy of most recent laboratory results from the inpatient facility.
   v. List of final discharge medications provided by the inpatient facility.
   vi. Copy of any prior authorizations obtained.
   vii. Copy of any medical consultations provided during the hospitalization from the inpatient facility.

F. A member of the ACT team shall maintain daily face-to-face contact with the member during the first 5 days (including weekends) following discharge. A minimum of 3 of the face-to-face contacts must occur at the member place of residency.

G. The ACT team will ensure the person’s AHCCCS provider or other primary care provider is notified of the person’s inpatient admission in accordance with the Primary Care Physician Coordination and Continuity of Care policy.

H. For persons considered to be at-risk for re-admission, the ACT team will meet weekly to discuss the person’s progress toward the goals identified in the discharge plan.

VI. Reviewing the Discharge Plan and Modification of the Treatment Plan
A. For persons who are either discharged or readmitted within the last 30 days, the following will occur within the next 7 days:
   i. The ACT Clinical Coordinator and a member from the ACT team will meet with the member for a clinical consultation to review both the discharge plan and ISP. The review will include:
      1. Determination of whether the discharge plan was successful in assisting the person in returning to the community upon discharge from the inpatient facility; and
      2. Determination of whether the ISP requires additional revisions because the person’s goals have changed or the interventions and methods of achieving the person’s goals are no longer current

B. If a member was court-ordered to receive treatment at the time of their inpatient admission, a review of the treatment plan will also include a review of the person’s STP. The person’s early warning signs or risk factors for non-adherence and the actions to be
taken or treatment that will be provided to address each early warning sign or risk factor shall be included.

C. The person’s ISP will be updated to incorporate the information listed in Standard VI. B. as appropriate.
Purpose

The foundation of evidence-based practices is client outcomes. The decision to implement an evidence-based practice is based on its ability to help clients achieve the highest rates of positive outcomes. Therefore, one key component of the implementation of an evidence-based practice is the careful monitoring and use of client outcome data. This protocol establishes expectations and roles for monitoring ACT member outcomes and processes.

Standard

1. Outcomes
   a. ACT staff shall monitor outcomes of ACT recipients in the following areas on a monthly basis:
      i. Psychiatric or medical hospitalization
         1. Total number of days in an inpatient psychiatric hospital
         2. Total number of days in a medical hospital
         3. Total number of members who were hospitalized in a psychiatric hospital
         4. Total number of members who were hospitalized in a medical facility
            I. Number of members who were readmitted.....
            II. Crisis Utilization (by outside providers not ACT team)
      ii. Incarceration;
         1. Total number of days in a jail setting
         2. Total number of members who were incarcerated
      iii. Homelessness;
         1. For housing stability
      iv. Independent living;
         1. For status of living arrangement
      v. Competitive employment;
      vi. For number of recipients employed
         1. Educational involvement; and
         2. For status of engagement in/completion of education
      vii. Stage of substance abuse treatment
   b. ACT Clinical Coordinator/APNO leadership will provide monthly reporting to ACT Manager.
      1. Census (not an outcome measure but still reported)
      2. Inpatient admissions, frequency and length of stay
      3. Incarceration
      4. Employment and MCA data
      5. PCP coordination efforts
      6. Members that are diagnosed with substance abuse issues/how many are members participating in services
c. ACT manager will aggregate, analyze, and disseminate outcome data in conjunction with ACT fidelity outcome audits.

   i. This data will be reviewed quarterly for the following:
      1. perform case reviews
      2. identify precipitating factors for readmission/incarceration
      3. identify service gaps
      4. recognize trends
      5. develop treatment protocols
Cross Reference(s)
NAMI National ACT Standards, SAMHSA, CARF Program Standards; CO.238.01DCC. Continuity of Care for Incarcerated Members

Purpose
To establish the hours of ACT team operation, place of treatment, and staff communication and service planning. The ACT program organization and communication structures must be solidly in place in order to provide highly individualized intense, well-organized, and multiple services to members while ensuring coordination of care.

Standards

I. Hours of Operation
   A. ACT teams shall be available to provide treatment, rehabilitation, and support activities seven days a week, 24-hours a day.
   B. ACT teams shall have 2 staff scheduled to provide services for a minimum of 12 hours per day each day. On call staff will be scheduled 24/7 and serves as a back up to the staff scheduled to work.
   C. ACT teams shall have 2 staff scheduled to provide services for a minimum of 8 hours on holidays.
   D. ACT Staff shall be available for on-call duty to provide crisis and other services during all hours not covered as regular operating hours.
   E. ACT Team psychiatrist is responsible for providing psychiatric back up during all hours not covered as regular operating hours.

II. Place of Treatment
   A. ACT teams shall provide 80% percent of service contacts in the community in non-office-based or non-facility-based settings.
   B. Data regarding the percentage of members contacts in the community will be collected and to ensure that the prescribed location of contacts is achieved. This will be gathered on a monthly basis by the ACT Clinical Coordinator.

III. Staff Communication and Planning
   A. ACT team staff shall conduct an organized daily staff meeting at a regularly scheduled time as scheduled by the clinical coordinator.
   B. A daily written log of the meeting shall be kept in a notebook. The log shall include the following elements:
      a. A roster of the members served in the program
      b. Date of last contact;
c. Primary diagnosis for each service recipient;
d. Date of last and next psychiatrist appointment;
e. Date of last and next nurse appointment;
f. Primary care physician contact information;
g. Date of last home-visit;
h. COT status of service recipient;
i. Column to track the implementation of action plans developed during the daily staff meeting

C. The daily staff meeting shall commence with a sequential review of the daily log to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day to day progress and status of all member.

D. The ACT team, under the direction of the Clinical Coordinator, shall develop a daily staff assignment schedule from the daily log that outlines the various daily tasks of each team member.

E. During the daily staff meeting, the ACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.
Level I (Inpatient) Assertive Community Treatment Referral Process

1. Inpatient and current outpatient team members, including the individual and legal representative when applicable, identify an individual as a possible ACT candidate.

2. Inpatient Team completes the Level I ACT Referral form along with a signed Authorization for Use and Disclosure (Release of Information) for the appropriate APNO and emails it to RBHA ACT leadership as identified on the referral form (this establishes the initial referral date).

3. RBHA ACT leadership team member completes his/her section of the Level I ACT Referral form and emails the document to the selected ACT team and site leadership for evaluation.

4. The ACT Team CC or designee and the Inpatient team will set a date to complete the face-to-face interview with the individual while including the guardian/legal representative and designated advocate in all steps throughout this process when applicable. The initial interview must be completed within 3 business days of the ACT team receiving the referral and completed ROI (It is not necessary for the Supportive Team to be present during the ACT evaluation but the current team must be invited). The ACT team should engage the member, several times if necessary, to give appropriate education about the services that are involved with ACT. The team should attempt to engage, a minimum of 3 times before declining the referral.

5. The ACT team will determine whether the ACT referral is accepted by the team and communicate that determination using the Level I ACT Referral form within 4 business days of the ACT team receiving the referral and completed ROI.

   a. If the person is determined eligible and is willing to transfer to an ACT Team, the ACT Team CC or designee will immediately join discharge planning activities and will schedule the transfer to occur within 7 days of the ACT evaluation. (Transfer will occur even if the person remains in an inpatient setting). The Evaluating ACT team will complete their section of the Level I ACT Referral form and email their acceptance of the referral to RBHA ACT leadership team as indicated on the form.

       • If the discharge plan changes so the individual is no longer targeted for ACT services, the individual will be immediately transferred back to the original team. All services should be outlined prior to scheduling the transfer to ensure that this will not occur.

   b. If the person is determined eligible but is not able to consent or is not agreeable to the team’s recommendation of ACT services, the individual’s decline of ACT services will be documented on the Level I ACT Referral form and emailed to RBHA’s ACT leadership team. The currently assigned team may work to engage the individual in ACT services while the person is still inpatient. If the individual becomes agreeable to ACT services, the team will document that agreement and notify the ACT team that completed the ACT evaluation. The ACT team will verify the individual’s agreement or may choose to accept the current team’s report of agreement within 5 days of notification. The Team will schedule the transfer within 7 days of the date the person’s consent to transfer is verified by the ACT Team.
c. If the person is determined not eligible for ACT Services, the ACT team will justify their conclusions in writing. The ACT team will deliver the Notice of Decision (NTXIX) or Notice of Action (TXIX/XXI) to the member, guardian, and advocate. It is also expected that a copy of the denial and the Level I ACT Referral document be sent to the RBHA ACT leadership team with an explanation of the decision within 3 days of denying the request for ACT services.

6. If the inpatient and/or current outpatient team disagrees with the denial delivered by the ACT team, that decision will be staffed with the evaluating ACT team, the referring Supportive team, the inpatient team, and RBHA in an effort to resolve the concerns at the lowest possible level.

**Supportive Team Outpatient Referral to an ACT Team**

1. Supportive Team CC or designee completes a transfer packet and submits it to the selected ACT Team per the transfer protocol.

2. Upon receipt of a complete transfer packet along with a signed Authorization for Use and Disclosure (Release of Information) for the appropriate PNO, the ACT CC or designee will initiate contact with the Supportive CC and coordinate a face-to-face meeting with the potential ACT candidate.

3. The ACT Team CC or designee and the Supportive CC or designee will set a date to complete the face-to-face interview with the individual while including the guardian/legal representative and designated advocate in all steps throughout this process when applicable. The initial interview must be completed within 14 days of the initial referral date from the current Team (It is not necessary for the Supportive Team to be present during the ACT evaluation but the current team must be invited).

4. The ACT team will determine whether the ACT referral is accepted by the team and communicate that determination to the referring team via secured email within 15 days of the initial referral date.

1. If the person is determined eligible and is willing to transfer to an ACT Team, the ACT Team CC or designee will schedule the transfer to occur within 14 days from the ACT evaluation.

   a. Since full fidelity to SAMHSA’s ACT model establishes a maximum of 6 referrals per month, ACT teams may schedule the transfer as far out as 45 days from the initial referral date if six or more referrals are already scheduled within the current month.

   b. If the person is determined eligible but is not able to consent or is not agreeable to the team’s recommendation of ACT services, the individual’s decline of ACT services will be emailed to the referring team. The currently assigned team may work to further engage the individual in ACT services. If the individual becomes agreeable to ACT services, the team will document that agreement and notify the ACT team that completed the ACT evaluation via secured email. The ACT team will verify the individual’s agreement or may choose to accept the current team’s report of agreement within 7 days of notification. The Team will schedule the transfer within 14 days of the date the person’s consent to transfer is verified by the ACT Team (please see fidelity note above for possible extension).
2. If the person is determined not eligible for ACT Services, the ACT team will justify the conclusion to the referring team via secured email. The ACT team will deliver the *Notice of Decision* (NTXIX) or *Notice of Action* (TXIX/XXI) to the individual with an explanation of the decision within 3 days of denying the request for ACT services.

**ACT Team to ACT Team Transfer** (follows time frames in transfer protocol and should be scheduled within 30 days of the requesting agency. If the member no longer will work with the transferring site, this should be expedited to ensure the member has appropriate levels of services.)
Purpose

Provider Network Organization ACT Staff supports the recovery goals of members to self-administer and manage their own medications. The ACT staff should support members in gaining insight and understanding of all of their prescribed medications. The purpose of supporting members in self-administration of physical and behavioral health medications is to educate and support members in their ability to independently adhere to their medication regimen.

Standards

I. Overview
   A. Assistance in the self-administration of medications, as defined in R9-20-408, includes one or more of the following:
      i. Storing the member’s medication.
      ii. Reminding the member to take medications as prescribed by the prescribing clinician. A prescribing clinician maybe the behavioral health medical practitioner, PCP, or other specialty prescribing clinician that the member is under medical care from.
         a. ACT staff should help the member to verify that the medication is taken as directed by the BHMP, PCP, or other prescribing clinician; confirming that the medication being taken is the correct medication prescribed.
      iii. Observing the member while they remove the medication from the container. Medications may be taken from pill bottles, bubble packs, or packaged medication containers.

II. Staff Assistance with the Self-Administration of Medication
   A. When the clinical team determines that the member requires self-administration of medication services, a treatment plan goal shall be developed with the member to include this goal.
   B. The prescriber will write an order for the assistance in the self-administration of medications including the frequency and the duration of time the service will be provided.
   C. After the order has been completed, the team will:
      i. Obtain a copy of the current medication flow sheet from all prescribing clinicians. This includes receiving directions from outside medical providers on the medication regimen that is prescribed outside of the behavioral health clinical team. It is recommended that the Registered Nurse be a point of contact to coordinate with medical providers.
      ii. Clarify with the prescriber any issues related to frequency, dosage, and medication ordered. The MD/ RN should complete coordination with all outside prescribing clinicians if there are concerns regarding the regimen.
      iii. Complete the medication observation form to include:
         1. name of medication ordered
         2. frequency
         3. dosage
D. The team will take the medication observation form and the medication flow sheet to the member’s home/residence on their visit for observation of self-administration of medications.

E. Observation of self-administration

Upon arrival at the members home/residence, the ACT staff will review the environment for potential dangers and will illicit help from their supervisor should they have concerns;

1. If the staff member observes that the member has medications that are not on their current medication regimen, the staff member will alert their supervisor for direction.

2. What is the reason for taking the medications? What do the medications help you with? If the staff member observes any adverse reaction to medication, they will immediately call a supervisor, prescriber, or nurse for consultation; life threatening emergencies necessitate calling emergency response team (9-1-1 to dispatch EMS). No medication should be taken if the staff member observes potential adverse reactions.

3. The staff member will observe the member take their prescribed medications.

4. The staff member and the member will both sign and initial the medication observation form after medication has been taken.

5. If the staff member observes that the member has medications that are not on their current medication regimen, the staff member will alert their supervisor for direction.

6. The medication observation flow sheet shall be filed in the member’s medical record.

7. Security of Medications
   a. At the member’s home/residence, the member should be encouraged to secure their medications safely away from others.
   b. If it is determined that the member cannot hold their prescribed medications safely at their residence, the prescriber can order to have the medications stored at the outpatient clinic and the member can come to the clinic daily for medication observation or daily doses can be taken to the member at their home/residence. If the medication is stored at the clinic, the medication will be secured in a locked cabinet, according to the provider’s policies and licensure requirements.

8. Assistance is Obtaining Refills
   a. During assistance in the Self-Administration of Medication, staff will educate and support the member in ensuring that they have adequate medications or if they are ready for a refill of their medications.
   b. The staff member may provide assistance to the member in calling the pharmacy for refills. If the member no longer has refills remaining on their prescription, the team member will notify the nurse to get a refill authorized by the prescriber. If refills are needed for medications by the PCP or other medical specialty provider the staff shall contact the prescriber to inquire about a refill. The RN
should be used, when necessary, to contact medical prescriber about refilling medications. After requesting a refill from the medical staff, the ACT team member will follow up to ensure that the prescription was called in and will assist with pick up from the pharmacy.

9. Refusing Medications
   a. Members have the right to refuse their medications. If the member refuses to take their medications, the staff member will document the refusal on the Medication Observation form and report the refusal to the prescriber as soon as they return to the clinic. The prescriber will offer education to the member about medication adherence. In the case of medical medications the clinical team shall coordinate with the medical prescriber upon return to the clinic and if needed assist in scheduling a follow up appointment.

10. Medication Error or Adverse Drug Reaction
   a. If the staff member observes a medication error such as the member is ingesting the wrong medication, wrong dosage, wrong frequency, or possible side effect of medication (that is not life threatening), the staff member will call the clinic and speak to the prescriber or nurse or contact the medical provider in the case of medical medications for further instruction/intervention. Complete an incident report for adverse drug reactions.
   b. If during the visit, the staff member notices a member having a seizure, difficulty breathing, or is unresponsive; the staff member will immediately call 9-1-1 for emergency services and will stay on scene until there is resolution.

11. Staff Member Qualifications and Training
   a. Trained ACT team staff can complete assistance in the self-administration of medications.
   b. Staff will be trained annually, in accordance with R9-20-204 (G)(1-4). Training shall include the following:
      i. Knowledge of medications commonly prescribed for members with behavioral health issues treated by the agency and medications commonly used to treat medical conditions.
      ii. Knowledge of the common benefits, side effects, and adverse reactions of those medications
      iii. Knowledge of the differences between assisting in the self-administration of medications and medication administration
      iv. Skills in assisting in the self-administration of medications
      v. Knowledge of medical terminology used in assisting in the self-administration of medication
      vi. Knowledge of the signs, symptoms, and indicators of toxicity or overdose and skill in identifying the signs, symptoms, and indicators of toxicity or overdose.
      vii. Skill in responding to a medication error or medical emergency
viii. Skill in documenting assistance in the self-administration of medication

c. Provider Network Organization training departments shall track this annual training requirement to ensure that all staff, that are not medical staff members, are up to date on this requirement. The following should be tracked:
   i. The staff members name, signature, professional credential, and job title
   ii. The date of the training
   iii. The subject or topics covered in training
   iv. The duration of the trainings
   v. The name, signature, and professional credential of the individual providing the training.

d. The Provider Network Organization Director of Nursing, or Medical Director should verify the skills and knowledge according to the requirements in R9-20-204 (F)(2) (c) by signing and dating the training exam.
Cross Reference(s)

NAMI National ACT Standards, SAMHSA, CARF Program Standards, Policy CO.284.02DCC Behavioral Health Recipient Contact Guidelines

Purpose

Assertive Community Treatment programs provide intensive services to member in the community settings. This protocol establishes a minimum staff-to-member ratio, minimum number of staff required to cover shifts, set frequency of staff service contacts with members, and gradual admission requirements.

Standards

I. Staff-to-Member Ratio
   A. Each ACT team shall have the organizational capacity to provide a minimum staff-to-Member ratio of at least one full-time equivalent (FTE) staff person for every 10 members
   
   B. Each ACT team requires a minimum of one FTE psychiatrist per 100 members.
      i. Nurse Practitioners, Physician Assistants, or Locum Tenums are not sufficient for this position.
   
   C. Each ACT team requires a minimum of one FTE registered nurse per 100 members. Per SAMHSA fidelity standards, 2 FTE RN’s is optimal.

II. Staff Coverage
   A. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services 24 a day, seven days per week. This should be a permanent schedule. Exceptions should only be made for vacancy and time off.

III. Frequency of Member Contact
   A. The ACT team shall provide multiple contacts per week with each member. For those members that are experiencing severe symptoms, trying new medications, experiencing health problems or serious life events, contacts should be adjusted to meet clinical need of the member. The staff should have the capacity to vary the intensity of ACT services to meet the changing needs of members.
      i. These multiple contacts may be as frequent as several times daily depending on the member’s needs. Frequency of contact can change often, depending on the needs but should be minimally 4 times a weekly with duration of 2 hours weekly contact (to meet SAMHSA fidelity) depending on members need. Staff members are responsible for assessing the needs of ALL members and adjusting frequency based on need.
   
   B. The ACT team shall have the capacity to rapidly increase service intensity to a member when his or her status requires it or at their request.
C. All members assigned to ACT services shall follow contact requirements that match SAMHSA fidelity standards. These include (but are not limited to) the following case management services:
   i. Four face to face contacts per week with the following specifications:
      a. 2 hours of face to face contact with the member in the community;
      b. One home-visit every 14 days.
   ii. Members in the hospital are to be seen every 72 hours (to include weekends and holidays);
   iii. Incarcerated members shall be seen once every 7 days with the following exceptions, unless clinically indicated otherwise by BHMP. The following exceptions exist:
      a. If the member is in an inpatient jail setting they shall be seen every 72 hours;
      b. As the member is nearing release, the ACT team should increase contact to prepare for release back into the community.

I. Visit with the BHMP as clinically indicated but not less than every 30 days;
II. Visit with the ACT RN as clinically indicated but not less than every 30 days;
III. At least one psychiatric assessment annually; and
IV. At least one nursing assessment annually.

D. Data regarding frequency of contacts shall be collected and tracked in the AM meeting log to monitor that the prescribed frequency of contacts is achieved.

IV. Gradual Admission of Team Members
   A. Each ACT team shall stagger member admissions no greater than 6 new members a month. Gradually building to capacity to serve not more than 100 members
Purpose

To establish expectations for supporting members with dual-diagnosis by providing the following standards as related to the below areas:

1. Organizational Features of Substance Abuse Services
2. Screening and Assessment for Co-occurring Use Disorders Treatment

Standards

I. Organizational Features of Substance Abuse Services
   A. Each ACT team shall have a minimum of two substance abuse specialists (license preferred)
      i. Substance abuse specialists shall take primary responsibility for the assessment, planning, and treatment of member with substance use problems.
      ii. Substance abuse specialist shall collaborate with and educate other members of the ACT team so that each member has a tightly coordinated treatment plan and all ACT staff can effectively participate in the treatment of substance use.
      iii. Substance abuse specialist shall have other team roles on the team (case manager, on-call coverage, one on one engagement with members to establish readiness)
      iv. Substance abuse specialists shall facilitate substance abuse groups at a minimum of monthly for ACT team members. Substance abuse specialists should use the stage wise treatment model for facilitation of these services. Groups should focus on stage of change and meeting members at their unique stages of readiness.
      v. Outside providers should be used for services that outside the scope of assertive community treatment team; these services should be coordinated by the team. Examples of services outside the scope of ACT team are:
         1. detoxification,
         2. induced remission of heavy substance use,
         3. licensed individual or group counseling,
         4. self-help programs (AA, NA),
         5. co-occurring residential treatment facilities.

B. ACT BHMP’s and RN’s shall actively participate in the evaluation, diagnosis and treatment of substance abuse disorders.
   i. BHMP will minimally meet monthly with the member and assess motivation for treatment, review member’s progress in treatment, and will make treatment recommendations that will guide the member’s treatment.

C. Participation in a substance abuse treatment program, abstaining, or promising to abstain from substance abuse SHALL NOT be a condition for admission or continued treatment on an ACT team.

D. ACT members with dual-diagnosis shall have a treatment plan that addresses substance use disorders and is aligned with a co-occurring approach.
II. Screening and Assessment for Co-occurring Use Disorders
   A. ACT SAS staff shall administer a basic screening for co-occurring substance use disorder within 30 days of intake and minimally every 6 months thereafter. The screening shall:
      i. Determine if a member does or does not warrant further attention at the current time in regards to substance abuse,
      ii. Use “yes” and “no” questions (e.g. Does the member show signs of possible substance abuse?)
      iii. Result in a recommendation for (or for not) administering a basic assessment of substance abuse.
      iv. Example screening tools include:
         1. Global Appraisal of Independent Needs- Short Screening (GAIN-SS)
         2. Mental Health Screening Form III (MHSF-III)
         3. Simple Screening Instrument for Substance Abuse (SSI-SA)
         4. Michigan Alcoholism Screening Test (MAST)

   B. If determined necessary by the screening, a trained SAS shall administer a basic assessment that covers key information required for treatment matching and or/treatment planning within 30 days of screening. The assessment shall:
      i. Obtain basic demographic and historical information and identification of established or probable diagnoses and associated impairments,
      ii. General strengths and problem areas,
      iii. Stages of change or stages of treatment for both substance abuse and mental illness,
      iv. Preliminary determination of the severity of the co-occurring diagnosis as a guide to final level of care determined.
      v. Example assessment tools include:
         1. University of Rhode Island Change Assessment (URICA)
         2. Global Appraisal of Independent Needs (GAIN)
         3. Addiction Severity Index (ASI)
         4. American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC)

III. Treatment
   A. ACT staff shall integrate dual-diagnosis treatment that adheres to a stage-based motivational interviewing non-confrontational model. This model shall include:
      i. Engagement,
      ii. Assessment,
      iii. Motivational enhancement,
      iv. Active treatment, to include cognitive skills training and community reinforcement,

   B. Treatment shall follow a harm reduction management model and strive to reduce the negative consequences of the member’s substance abuse. The treatment process shall:
      i. Develop motivation for decreasing substance abuse,
      ii. Develop coping skills,
iii. Develop recognition of negative consequences for use,
iv. If desired by the member, develop abstinence goals.

C. As determined clinically appropriate, treatment activities shall include:
   i. Individual treatment
   ii. Stage-wise groups
   iii. Persuasion groups
   iv. Family intervention
   v. Self-help groups
   vi. Community reinforcement activities
Key Terms

Assertive Community Treatment (ACT)

A self-contained mental health program made up of multidisciplinary mental health staff members who work as a team to provide the majority of treatment, rehabilitation, and support services service recipients need to achieve their goals. ACT services are individually tailored with each member through relationship building, individualized assessment and planning, active involvement with service recipients to enable each to find and live in their own residence, to find and maintaining work in the community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The ACT team is mobile and delivers services in community locations rather than expecting the member to come to the clinic. Eighty percent or more of the services are provided outside of the clinic in locations that are comfortable and convenient for the service recipient. The service recipients served have severe and persistent mental illnesses that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. Case load size should be low so that intensive services can be maintained (SAMHSA tool states case load size 10:1)

Each ACT team should have the following specialty positions:

1 Psychiatrist
2 Registered Nurses
1 Case Manager
2 Licensed Behavioral Health Professionals (Substance Abuse Specialists)
1 Independent Living Specialist
1 Peer Support Specialist
1 Housing Specialist
1 Rehabilitation Specialist
1 Employment Specialist
1 Program Assistant
1 Clinical Coordinator

Member

A person who has agreed to receive services and is receiving client-centered treatment, rehabilitation, and support services from the ACT team.

Recovery

The “overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self- esteem and identity and on attaining meaningful roles in society.” (Mental Health: A Report of the Surgeon General, 1999, p 97)

Crisis
A crisis can refer to any situation in which the individual perceives a sudden loss of his or her ability to use effective problem-solving and coping skills. Policy Terms & Definitions are available should the reader need to inquire as to the definition of a term used in this policy.