Assertive Community Treatment

Magellan Behavioral Health of Pennsylvania (Magellan) Performance Standards

Performance Standards are intended to give guidance for contracted services as part of the HealthChoices program, with a goal to promote the utilization and progress toward providing best practices performances, to increase the quality of services and to improve outcomes for members.

Current Version Information

Substantive changes in most recent update:

1. Scope of services – additional clarification related to minimum contacts
2. Expectations of service delivery – further detail related to documentation expectations

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is a Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews; but also share with providers as needed to communicate expectations and best practices. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania regulations and requirements, including but not limited to ***Assertive Community Treatment (ACT) must also be compliant with Medical Assistance Bulletin OMHSAS-08-03****, as well as all other applicable MA Bulletins, licensing requirements and any contractual agreements made with Magellan Behavioral Health of Pennsylvania, Inc. in order to be eligible for payment for services. All providers must also ensure compliance with their approved Service Descriptions.*

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https://www.magellanofpa.com/for-providers/

Level of Care Description

Assertive Community Treatment (ACT) is a service delivery model for providing comprehensive community-based treatment to persons with serious and persistent mental illness. ACT is a self-contained mental health program made up of a multidisciplinary mental health staff who function as part of a team. This team provides the majority of an individual's treatment that is needed to achieve identified goals. The multidisciplinary team ensures integrated and ongoing intensive treatment that is individualized and includes assessment, rehabilitation, and community support services.

Scope of Services

ACT teams serve individuals aged 18 and older with a diagnosis of serious and persistent mental illness, particularly Schizophrenia, Schizoaffective Disorder, and Bipolar Disorder. These individuals may also have co-occurring substance use disorder issues and are at risk for decompensation and re-hospitalization even with the availability of traditional community-based services. ACT teams can serve up to 120 individuals, however, the recommended census is 100 on an ongoing basis. ACT treatment is

based on continuous need and there are not concrete time frames associated with length of stay, however, services are designed to move individuals toward independence and are not to be considered lifelong services.

ACT teams operate continuously 24 hours a day, 7 days a week, 365 days a year via worked shifts as well as on call during non-business hours. Weekdays are comprised of face-to-face contact from 8:00 AM through 8:00 PM, with at least two staff members working between 4:00 PM – 8:00 PM. Weekends are comprised of two individuals working at least an 8-hour shift to provide face-to-face contact as needed with on-call support during the remaining hours. These services are provided in a multitude of locations in the community, including in home or other community settings where an individual might currently be located. Services can be provided in the team's office setting, such as in group format, however, the majority of services should be community based in nature. Contacts **can occur as frequently as needed, but at a minimum there should be three face-to-face visits per week across all members, including an average of two hours of face-to-face contact per week across all members.** Members receiving ACT services are generally some of the most vulnerable, therefore the three contacts per week is a floor, not a ceiling. While the intensity of services will vary over time for each member, teams consistently averaging less than the required contacts and hours should evaluate whether the members need more frequent ACT contact or are no longer in need of the intensity of an ACT program.

Service Description

An ACT team is comprised of a multidisciplinary team in which a sufficient number of personnel is needed to provide the intensity and frequency of support to assist this population. The team members to individuals served ratio should not exceed 10:1, excluding the psychiatrist and program assistant. If the severity or complexity of need of the currently served individuals is high, teams should consider operating under lower ratios in order to ensure quality service is offered consistently. If a team is serving above the recommended maximum number of individuals (100), the team will provide an additional 1.6 hours of psychiatric coverage for every 5 additional individuals.

The team should be made up of 10-12 staff members at a minimum, excluding the psychiatrist. The team should be comprised of the following types of personnel:

- Psychiatrist: Pennsylvania (PA) licensed and offering at least 32 hours per week for every 100 individuals admitted to the team.
    - This hourly amount could be achieved by two physicians working with a team in which total hours are equal to or exceed 32, however, best practice is to employ a single psychiatrist to work with all individuals. If multiple psychiatrists are fulfilling this role, there must be a mechanism in place to ensure consistent communication and consultation between the physicians.
- Team Leader (TL): full time master's level clinician, registered nurse, or psychiatrist who serves as the clinical and administrative supervisor of the team. Best practice is to have a team leader who has a current PA license in either psychology or social work. The team leader also functions as a practicing clinician and provides 10 hours a week of direct services to individuals admitted

to the team. The team leader providers group supervision at least once every two weeks and individual supervision sessions at least once every two weeks to any team member who providers direct service to individuals other than the psychiatrist. The team leader should have at least two years of supervisory experience prior to becoming the team leader and should be a certified peer specialist supervisor or obtain the certification within six months.

- Registered Nurse (RN): three total RNs are to provide support as part of the team. A team leader with a nursing degree may not be utilized as one of those three nursing positions. Registered nurses on the team should have previous experience working with individuals with serious and persistent mental illness and collaborate with the psychiatrist in managing the medication system, administration and documentation of medications, developing strategies to maximize individuals taking medications as prescribed, screening individuals for medical problems or medication side effects, collaborate and coordinate medical services with other providers, offer health education, promotion, and prevention strategies, and providing training to other team members on how to monitor psychiatric symptoms and medication side effects.
- Mental Health Professionals (MHP): the team should have at least four master's level or above clinicians on the team, excluding the team leader. It is recommended that at least one of the master's level clinicians have a degree in social work. While not required, licensed clinicians are recommended whenever possible. Mental Health Professionals can serve a dual role of clinician and specialist, such as co-occurring, housing, or vocational specialist on the team.
- Substance Abuse Specialist (SAS): at least one team member must be a Certified Alcohol and Drug Counselor or a Certified Advanced Alcohol and Drug Counselor. The Substance Abuse Specialist may be one of the team's master's level therapists if the team member possesses the correct educational level. The SAS uses systematic integrated screening and assessment, tailors interventions to those in all stages of change readiness (such as outreach, motivational interviewing, cognitive behavioral approaches, and relapse preventions), models skills for other team members, offers consultation to other team members, attends treatment planning for all individuals identified as having co-occurring disorders, and provides consistent cross training to the team.
- Certified Peer Specialist (CPS): at least one team member must be a Pennsylvania Certification Board certified CPS. The CPS must be a full professional member of the team and is integrated into all responsibilities that team members have. Peer Specialists should be engaged in coaching and consultation to promote recovery and self-direction, providing instruction on WRAP as well as other wellness management strategies, and offering cross training and modeling to other team members.
- Vocational Specialist: at least one clinical team member should be designated as the vocational specialist. The vocational specialist provides services following a Supported Employment model focusing on assessment, job development/placement/coaching, cross training and modeling for other team members, and attending treatment planning meetings for those individuals with employment goals. Having a designated individual who primarily handles vocational goals should not preclude all other team members from developing a level of proficiency in identifying and assisting members with employment goals and working toward employment opportunities. It is recommended that all team members are comfortable with providing vocational support and guidance to members.

- Remaining clinical staff: remaining team members may be a mixture of bachelor's level and paraprofessional mental health workers. Teams would be best served to identify at least one team member as a housing specialist. This team member should have experience with working with the homeless population. It is also recommended that at least one member of the team also hold the certification of Certified Psychiatric Rehabilitation Practitioner (CPRP). As with the vocational support, it is recommended that all team members are comfortable with providing housing and psychiatric rehabilitation support and skills coaching to all members.
- Program Assistant: the team should have at least one identified and solely dedicated program assistant. The program assistant should assist the team with managing all non-clinical operations, assist with daily team schedules and providing support to team members out in the field, managing team information, accounting, and budgeting, triaging incoming member calls and ensuring coordination and connection between team members.

ACT services are expected to be assertive and engaging in both intensity and frequency. Services should be delivered face-to-face while in a community setting. Phone contact or telehealth with members, natural supports, and collaterals can occur, but this should not be the primary method of interaction utilized by team members. Since members need the most intensive level of community-based services, contacts should be frequent, consistent, and intensified quickly based on emerging level of need for each individual member. On average and at a minimum, the team should provide at least two hours of service over three face-to-face visits per member, per week. Program Director's should be monitoring members service utilization on a regular basis and addressing through appropriate clinical/administrative interventions any over or under-utilization to ensure members are receiving the appropriate amount of services to meet their clinical needs.

The goal of each contact should be derived from the current comprehensive treatment plan and reflected in the member's monthly schedule card to allow for continuity of care amongst team members and allow for the member to be aware of when and what contacts will entail. If an emerging need is present upon meeting with the member, the visiting team member should address that need as well as the previously scheduled task if possible. The team should document all attempts at contact with a member in addition to those contacts that occur as expected.

Service Exclusions

Individuals under the age of 18 are not able to receive ACT services. Individuals with a primary diagnosis of substance use disorder, intellectual disability, or brain injury are also not the intended target group for ACT services.

ACT services are designed to meet all of an individual's treatment needs. Therefore, some services are considered duplicative when receiving ACT services such as Intensive or Blended Case Management (ICM/BCM), Site-based or Mobile Psychiatric Rehabilitation Services, Peer Support Services, Mental Health Partial Hospitalization Program Services, Mental Health Intensive Outpatient Treatment, Mental Health Outpatient Services (including individual, family, or group therapy or psychiatry), and Dual Diagnosis Treatment Team (DDTT). On occasion and for approved clinically appropriate reasons,

specialty outpatient services can be concurrently approved on a case-by-case basis and with prior approval from a Magellan Care Manager.

If an individual is receiving certain services or is residing in certain placements for longer than 30 days while involved with ACT services, the individual also becomes unable to continue with ACT services. Receiving treatment in long term treatment locations such as Extended Acute Care (EAC), State Hospital, Long Term Structured Residences (LTSR), or All-Inclusive Residences (AIR) will disqualify individuals from continuing to receive ACT services, and they would need to be discharged. Other types of ongoing placement and/or treatment that disqualify a member for continued ACT services requiring discharge would be incarceration or long-term medical placements, such as skilled nursing facilities. For members residing in a Community Residential Rehabilitation (CRR) program, there should be clearly defined goals with associated roles and timeframes to meet the required independence for the member to remain in the CRR without ACT support.

Referral Process

In most cases, a referral to ACT services is voluntary, as is participation in the program. If an individual is under a legal commitment to receive ACT services, a referral would also be made at that time. Upon expiration of the legal commitment, ACT teams shall discuss continued participation in the program with the individual to continue with services. Referrals to ACT services can come from a variety of settings. Referrals are received from community hospitals, Extended Acute Care units, State Hospitals, homeless shelters, jail/prison, outpatient providers, case management, and any other types of community organizations that come in contact with a qualifying member. ACT teams should develop and maintain relationships with funding sources to actively recruit members who would qualify and benefit from this level of service.

All referrals must be submitted to ACT providers utilizing the County/provider designated referral form and be accompanied by documentation of the individual's clinical presentation. These supporting documents must at a minimum include a psychiatric evaluation. Other preferred documents are current insurance information, treatment history, psychosocial history, recent lab results, recent progress notes, and any other documentation the referring party feels will show support for establishing ACT eligibility. Upon receipt of the referral, ACT teams will review the documentation provided and make a determination regarding the individual meeting eligibility requirements. If a member does not meet eligibility criteria upon review of documentation, ACT teams shall contact the referral source and request additional details if available or will in absence of other supporting information, encourage the referral source to seek out more appropriate services.

If an ACT program feels that an individual meets criteria based on documentation but are unsure if the member is a good fit for the services or there is a concern about an individual’s level of agreement with ACT, the team will conduct an in-person assessment to gather additional information and ascertain agreement to participate in the program prior to making a decision about accepting the referral. Candidates may choose to have natural supports or current treatment supports attend this in-person assessment to learn about the program and/or offer additional insight.

It is recommended that ACT teams admit new members on a gradual basis and should strive to admit no more than six new individuals per month. At times, this can cause a need for a waiting list comprised of members who meet eligibility criteria and are interested in working with the team but are unable to be admitted until slots are available via discharges of current members. While teams may be able to provide a general estimate of when a slot may become available, treatment can be fluid and timeframes may change at any time. Members may also be referred to other available programs if they are on a waiting list and are uncomfortable with the current wait time. Wait list positioning can also be determined by an individual's current treatment situation and the severity of need in addition to the order in which a referral is received.

Admission Process

Prior to admitting an individual to ACT services, teams will review and confirm the member meets Medical Necessity Criteria for ACT services at the time of admission. Medical Necessity Criteria that must be met for ACT admission includes: 1) member is over the age of 18, AND 2) member is diagnosed with a serious and persistent mental illness such as Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder as well as having a psychiatric evaluation recommending ACT level of care, AND 3) member meets at least two of the following criteria – at least two inpatient psychiatric hospitalizations or lengths of stay totaling 30 or more days inpatient in the last 12 months; intractable, severe major symptoms, co-occurring mental health and substance abuse disorders with more than 6 months duration at the time of contact; high risk or recent history of criminal justice involvement such as frequent contact with police, incarceration, probation or parole, literally homeless or at risk of imminent homelessness or residing in unsafe housing; or residing in an inpatient setting or supervised community residence but are clinically assessed to be able to reside in a less restrictive setting AND 4) difficulty effectively utilizing outpatient or case management levels of treatment or evidence that the individual requires a more assertive and frequent non office based service to meet current clinical needs.

Members can be admitted to ACT services from a variety of care locations, including, but not limited to, residing in the community, inpatient placement (including community hospitals, Extended Acute Care, and state hospitals), crisis residential programs, or during incarceration. If a member entering into ACT services is residing in any 24-hour level of care or incarceration, ACT services may admit and begin meeting with the member for up to 30 days prior to discharge to allow for rapport building, assessment, and transition assistance prior to the member returning to a community setting. If the member is not discharged within the 30-day timeframe from admission date with ACT, the team shall discharge the member with the understanding that re-admission to services can occur when discharge is imminent.

On the day of admission, the ACT team leader or clinician will meet with the member and any natural or treatment supports the member chooses to have present to go over informed consent, etc. Any needed release of information forms for other involved providers (such as any primary or specialty

physicians providing medical care, natural supports, previous mental health providers, county base service units providing ongoing funding, supportive housing providers, etc.) should be signed at this time and team should begin coordinating care and/or transition of the member if any other provider would be considered a duplication of services (such as case management, outpatient therapy, peer support, psychiatric rehabilitation, etc.) and need to discontinue services with the member. An overlap period of 30 days post admission can be utilized to provide appropriate clinical closure and transition for the member from these previous services to full care being provided by the ACT team. An initial biopsychosocial assessment will be completed by the team leader or clinician on the day of admission. This assessment will be comprised of demographic information, presenting problem which includes in the individual's own words, reason for treatment, availability of supports and resources, treatment/social/developmental history, current level of functioning, physical health and medications, a justification for admission and the assignment of a primary team member to work with the individual. This assessment can be from member self-report, natural support reports, and written summaries from other agencies.

During this admission appointment, the ACT team leader or clinician will also complete a treatment plan to be used for the initial 8 weeks following admission while the member is acclimating to the team and completing comprehensive assessments. This initial treatment plan shall contain at a minimum: problems to be addressed, short term goals, and objectives. The plan must be a collaboration between the individual and clinician and can have natural support input as well. Both the team leader and the individual must sign this plan for it to be active. The individual and team leader will also complete a safety/crisis plan to be utilized by the team to support the individual going forward. This crisis plan can be augmented or updated at any time going forward. The individual and any natural/treatment supports shall also be educated on the procedure for contacting the team during normal business hours as well as during on call times.

During the first 6 weeks following admission, the team will work with the individual on completing comprehensive assessments and a timeline to allow better understanding of the individual's history, current level of functioning/needs, and overall goals for treatment. Comprehensive treatment planning will flow from the information collected during these assessments. A team member with expertise, training, or interest in the domain the assessment covers should be selected to complete the assessment with the member. Once the assessment is completed, the team member will offer recommendations for treatment planning based on the information gathered in that particular assessment. The assessments and timeline cover the following domains:

- Psychiatric: This must be completed by the team psychiatrist and should cover psychiatric history, mental status, and diagnosis assessment. The psychiatrist will utilize the clinical information gathered to make an accurate diagnosis utilizing DSM V criteria.
- Physical Health: A team registered nurse must complete this assessment and at least the first interview should occur within 72 hours of admission to the team. This assessment should address a thorough assessment of health status, medical conditions present, and any needed follow or medical coordination that are needed.
- Substance Abuse: The Substance Abuse Specialist or another team member with training and experience in dual diagnosis should complete this assessment. This assessment should address any historical or current use of substances or alcohol.

- Education and Employment: The Employment Specialist or another team member with training and experience in vocational services should complete this assessment. This assessment should cover any history or current academics or employment status, interests in academics or employment, and detail how symptoms may have or are affecting any past or current academics or employment.
- Social Development and Functioning: A team member with interest in this area may complete this assessment. Teams may choose to have the Certified Peer Specialist complete this assessment. This assessment should address childhood, early attachments, role in family of origin, adolescent and young adult development, culture, religious beliefs, leisure activities, interests, and social skills.
- Activities of Daily Living (ADLs): It is recommended that a team nurse complete this assessment as they have training in this area. If this is not possible, another team member with training or interest in this area can complete the assessment. This assessment should address the member's current ability to meet basic daily needs, quality and safety of their living environment, financial resources, symptoms effects on ability to care for self, and the ability to maintain one's current living situation in a safe manner.
- Family Structure and Relationships: This assessment should be completed by members of the individual treatment team. Teams may choose to have this assessment completed by a mental health professional that is part of the Individual Treatment Team (ITT) team. This assessment should address natural supports and their view of the member's mental health needs, symptoms, and expectations of treatment. This assessment can help the ACT team determine to what extent natural supports will be involved in identifying goals, treatment, and rehabilitation.
- Psychiatric and Social Functioning Timeline: The timeline should contain information about the chronology of the member's treatment history, experiences with mental health, and any significant life events.

Treatment or Service Plan

Treatment plans utilized by the ACT team shall be comprehensive and focus on person-centered goal planning. The initial comprehensive treatment plan must be developed within 8 weeks of a member's admission and is reviewed and updated at a minimum of every 6 months thereafter. Comprehensive treatment plans should be updated more frequently if treatment circumstances indicate a need for changes and can be updated as frequently as needed.

While initial comprehensive assessments are part of the admission process to ACT services, teams should be continuously re-assessing members throughout their time in treatment to ensure that goals and treatment are aligned appropriately to where the member is currently at and where they would like to go in their recovery. Continuous assessment should be centered around mental health treatment, but also in the areas of physical health, substance abuse, education, employment, and all other life domains that may show areas of need.

Comprehensive treatment plans should be individualized and person-centered. Member's strengths should be highlighted in these plans and their input is the driving force behind goal development. These plans should include a summary of the main concerns, progress, or lack thereof from previous goals/objectives, and barriers to obtaining goals. The comprehensive treatment plan is the central focus and guide for the members treatment and includes input from the member as well as any natural supports the member chooses to have participate in the plan development. The plan should contain sections identifying specific needs, problems, specific and measurable goals and objectives, interventions that address all life domains, and persons responsible.

Prior to the development or updating of any comprehensive treatment plan, an individualized treatment team meeting must occur to complete goal planning. This meeting is to be attended by the ITT members and the team leader. It is highly recommended that the member attends as well as any other member identified supports. The member should always be given the choice to attend and have participation encouraged, however, a member is not required to attend the meeting if they do not wish to do so. Any other involved team members, such as specialists or the psychiatrist are highly encouraged to attend this meeting as well. The topics discussed in the meeting should include member's strengths, progress, and goals for the various life domains, such as psychiatric treatment, employment and/or education, housing, symptom management, rehabilitation, interpersonal relationships, daily structure, legal concerns, substance abuse, and crisis planning. The plan should also have documentation surrounding problem areas, strengths, barriers, long term goals, progress toward goals, specific interventions, what each responsible party will do (including both member and team members), and discharge planning.

Upon completion of the plan, the member, primary team member, team leader, and psychiatrist shall sign and date the plan. The remaining team members should also review, sign, and date the plan within two weeks of completion.

Expectations of Service Delivery

The hallmark of ACT services is assertive outreach, and the majority of services are expected to be delivered in the individual's natural environment. ACT services are guided by the principle that individuals be maintained in a community setting, in the least restrictive level of care, with the focus on assisting individuals in achieving a maximum level of independence and an overall enhancement in their quality of life. ACT teams should be providing at least 75% of their services in non-office based or facility-based settings, instead focusing on working with the individual in places like their home, neighborhood, place of employment, recreational facilities, higher education sites, or any other location an individual may interact with others. Providing services in natural settings will allow for better transfer of skills and allow for observation and assessment of an individual in real life situations rather than relying solely on self or staff report.

In order to ensure the team is communicating, and up to date, on current details about each member, the team shall attend a daily meeting (weekend days and holidays not required to have a full team meeting). These meetings are to be attended by all staff members available, including the program assistant and psychiatrist. During the meeting, each member receiving services is reviewed, including

details around the most recent contact, any on-call/crisis concerns, and upcoming scheduled visits. This meeting should also address any emergent or changing needs the members may have and ensure that all visits and needs of the day are accounted for and covered by team members. A shift manager may be utilized to manage duties and would be a member of the team rotated on a daily basis. The team will keep a daily log that is completed during the daily meeting. The log contains entries for each member being served by the team and is comprised of details of any interactions the team had with the member in the last 24 hours (or 72 hours if immediately following a weekend). Program Directors should be monitoring members service utilization on a regular basis and addressing through clinical/administrative interventions any over or underutilization to ensure members are receiving the appropriate amount of services to meet their clinical needs.
The team shall also keep updated schedules for team members' contacts with members as well as a schedule for each member being served. Team members' schedule of daily visits should show consistency over each week but can vary as a result of the additions of any prioritized visits due to increased acuity, coverage, or any emergency/crisis situations. Member schedules should be based on the interventions discussed in their treatment plan, should be member driven regarding dates and times of scheduled visits, and should also take into account any community-based activities outside of the team that the member engages in.

ACT teams should be the main point of contact for their members and shall operate as the accountable provider for each member's community-based treatment. The team provides the following types of services:

- **Service Coordination:** Assigned case manager who coordinates and monitors the individual's activities with the team, and links with community resources that promote recovery.
- **Crisis Assessment and Intervention:** Available 24 hours a day seven (7) days a week, including telephone and face-to-face contact.
- **Symptom Assessment and Management:** Ongoing comprehensive assessment and accurate diagnosis, psychoeducation regarding mental illness and medication management, symptom self-management, and supportive therapy.
- **Medication Prescription, Administration, Monitoring, and Documentation:** The ACT psychiatrist shall establish an individual clinical relationship with each individual. As referenced in the ACT bulletin (pg. 17), will assess monthly the individual's symptoms and response to medications including side effects.
- **Dual Diagnosis Substance Abuse Services:** Integrated treatment that addresses the inter-relationships between mental health issues and substance use. While the substance use needs to be a consideration during treatment, ACT teams cannot provide substance use treatment without a license from the Department of Drug and Alcohol Programs (DDAP).
- **Work-related Services:** Assist the individual to value, find, and maintain meaningful employment.
- **Activities of Daily Living:** Includes housing, household activities, personal hygiene, money management, use of transportation, access physical health resources.
- **Social/Interpersonal Relationship and Leisure Time Training:** Activities to improve communication skills, develop assertiveness, increase self-esteem.

- **Peer Support Services:** Linkages to self-help programs and organizations that promote recovery.
- **Support Services:** Assistance to access medical services, housing, financial support, social services, etc.
- **Education, Support and Consultation to Individuals' Families and other Major Supports:** Includes psychoeducation related to individual's illness and role of the family, linkages to family self-help programs and organizations that promote recovery.

While ACT is a voluntary service, teams should put a great deal of effort into actively engaging and maintaining members throughout the treatment process. Engagement needs to be an ongoing process and the effort and importance of engagement put forth by the team should remain present during the duration of treatment and should also be tailored to the needs of the member at any given time in the process. Engagement strategies should be varied, thoughtful, and directed to the specific needs of each member. ACT teams should look to engage the member and any natural supports at all times, including throughout the initial assessment and admission process and meeting the member wherever they may be, not only in their level of commitment, but physically, such as in their homes, school, place of employment, during hospitalization, etc.

Teams should utilize techniques such as therapeutic limit setting and Motivational Interviewing to maintain engagement and relationships with members. The ACT team should also look for markers or behavior that might indicate a member would need more assertive engagement and increase effort and strategies with the member at that time. These signs could include missing appointments, lack of good rapport or trust in the therapeutic relationship, inpatient placement, increased or frequent crisis situations, homelessness or risk of homelessness, loss of natural supports, high risk behaviors, or substance use that may be interfering with ability to engage in treatment.

In order to continue receiving ACT services, members should continue to have a valid DSM 5 diagnosis, which remains the principal diagnosis, and continued SPMI symptomatology affecting the member's ability to function in the community, and to access and utilize traditional treatment services. It is expected that a psychiatric evaluation has been completed at least once a year and continues to recommend ACT level of care. There should also be evidence that the member is benefiting from the continued involvement of the ACT team. These benefits should be shown by positive or a lack of response in areas such as medication adherence, reduction in inpatient placements, or improvement in community supports. Treatment planning and subsequent therapeutic interventions must reflect appropriate, adequate, and timely implementation of all treatment interventions in response to the individually changing needs. The member should be assessed consistently for transition using the ACT Transition Readiness Scale and be determined to continue to need to develop more skills and independence to transition to a lower level of care and show a lack of at least 6 months of stabilization at baseline and continues to meet admission criteria showing a need for this level of intervention.

Documentation

The documentation in an individual's record allows behavioral health professionals to evaluate and plan for treatment, monitor progress over time, and facilitate communication and continuity of care

among healthcare professionals involved in the individual's care. It ensures accurate and timely claims review and payment, promotes appropriate utilization review and quality of care evaluations, and can be used for research and education.

In addition, the following are important to follow and align with the minimum Medical Assistance documentation requirements:

- The record must be legible throughout.
- The record must identify the individual on each page.
- Entries must be signed and dated by the rendering ACT team member.
- Alterations of the record must be signed and dated.
- The Treatment Plan and all subsequent revisions must be entered in the record.
- The record must indicate the progress towards goal at each session, change in support and response to interventions.
- The disposition of the case must be entered in the record.
- The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.
- The progress notes for all services, at a minimum, must include:
    - The specific services rendered;
    - The date the service was provided;
    - The name(s) of the individual(s) who rendered the services;
    - The place where the services were rendered;
    - The relationship of the services to the individual service plan – specifically, any goals, objectives and interventions.
    - Progress at each session, changes in support and response to support;
    - The actual time in clock hours that services were rendered.
    - It is critical that progress towards the goal identified in the Treatment Plan also be documented in a progress note.

Care Coordination

The ACT team is expected to maintain good collaborative relationships with any other service providers or natural supports that are involved in the members' lives. This includes times when the member is out in the community and well as in any 24-hour levels of care, such as inpatient psychiatric hospital, substance use treatment, and crisis residential placements. ACT teams should also be aware of any other services a member is receiving and address any that are a duplication of the services they are responsible for providing.

ACT teams should coordinate with any physical health providers, including primary or specialty services, to allow for continuity of care. Best practices also include maintaining information regarding any changes to medications or medical conditions as they occur. It is recommended that the team also keep close contact with any member who may be receiving inpatient or short term residential medical treatment. ACT teams should also coordinate with any natural supports that members have requested

to be included in their treatment via releases of information in order to allow for constant natural support. ACT teams should also develop and maintain collaborative relationships with any supportive housing providers or other treatment services that a member is involved in outside of the team. If a member is involved in a service that is a duplication of ACT services, the team should work with both the member and the service provider to transition the member into full team participation for those services.

The ACT team also shall provide ongoing contact and collaborations for members that are in any out of community placements/24-hour levels of care for both psychiatric and substance abuse reasons. Team members shall be involved and assist in the evaluation and admission process and be in contact with both the member and provider within 48 hours of the admission so the team can furnish information, conduct appropriate assessments, assist with addressing or communicating any member needs and begin to work on appropriate discharge plans. The team is responsible for meeting with the member face-to-face at least once weekly and maintaining consistent contact with staff for care collaboration. The team shall also transition the member back into the community and maintain at least three face-to-face contacts per week, for at least one month post discharge.

Discharge Planning and Transition

Discharge planning should begin immediately upon intake and the expectations and course of treatment should be discussed with any member during the admission process. Teams should discuss achievement of long-term goals and markers for discharge at each treatment plan update and be consistently assessing members for discharge readiness throughout the duration of engagement with ACT services, including barriers to discharge, progress of discharge planning, and any changes to discharge plans. ACT teams shall not have any arbitrary time frames for discharge and instead shall base readiness for discharge on the attainment of mutually agreed upon goals. Teams should strive to discharge 5% or less of their caseload over a 12-month period due to lack of engagement. When gauging discharge readiness, it is expected that teams will utilize The Assertive Community Treatment Transition Readiness Scale (ATR) every six months along with a comprehensive treatment plan. Teams may also utilize additional assessment methods or tools to gage discharge readiness and teams are expected to evaluate the totality of the current circumstances to determine if discharge is appropriate. Teams should continuously review with member progress on goals that position them well for discharge readiness.

In order for discharge to be considered, a member would meet one or more of the following criteria:

- The individual and the team determine, based on the attainment of goals as identified in the individual's treatment plan, that ACT services are no longer needed.
- The individual moves outside the geographic area of the ACT team's responsibility. In such cases, the ACT team will arrange for a transfer of mental health services responsibility to an ACT program or other provider within the members new geographic location.
- The individual chooses to withdraw from ACT services and attempts to re-engage with the service have not been successful.

- Members who consistently did not utilize the recommended amount of ACT services should be assessed for alternative levels of care to meet their needs and prepare for discharge.

When a member is determined to be ready to transition toward a lower level of care services, the ACT team shall update the treatment plan to reflect transition plans and services. This time period should continue to focus on independence in all areas of life and the team working to support the member in moving toward utilizing outpatient treatment services, natural supports, and other community resources so that the member is able to become comfortable with utilizing a variety of supports on a more independent basis. The ACT team will provide psychoeducation to the member and any natural supports involved around types of treatment services and community supports that are available to the member once discharge occurs.

ACT teams are able to continue to support members for up to 30 days once transition to non-ACT service providers has occurred. It is encouraged that ACT team members either attend initial appointments with outside psychiatric services with the member during this time or at a minimum follow up with both the member and the service provider to verify attendance and offer assistance in identifying and rectifying any barriers that may exist to successful transition. Once a successful discharge has taken place, the ACT team shall notify Magellan within one business day. ACT shall provide the date of discharge, reason for discharge, and time/date/name of appointments with community service providers.

Outcomes

All providers of ACT should have policies and procedures in place to evaluate outcomes for the program. Indicators that may be considered include:

- Number of higher level of care admissions.
- Number of crisis contacts.
- Participant satisfaction.
- Frequency of contact with members and families.
- Community Tenure.
- Scores on the ACT Transition Readiness Scale.

Performance Outcome Management System (POMS) is a tool that DHS established to continuously evaluate the effectiveness of the HealthChoices' program. POMS allows DHS to identify members with a serious illness or risk of illness; establishes a data baseline for member functioning at registration or entry into the HealthChoices' system; updates member data as the course of treatment evolves; and finalizes member data at closure of treatment.

HealthChoices' providers are ***mandated*** by DHS to collect priority population data and submit POMS data on every HealthChoices' member receiving mental health services at certain points during treatment.

These include the following:

- When you are seeing the member for the first time (initial registration).
- When you are seeing the member for the first time under HealthChoices (the member may have seen you as a fee-for-service patient and subsequently converted to HealthChoices).
- When you are seeing the member for the last time (either termination from your care, if the member is moving to another provider; or closure, if the member is ending all mental health treatment).
- Whenever there is a change in any POMS element.

Complaint Process

Magellan provides a formal mechanism for all members to express a complaint related to care or service, to have any complaints investigated and resolved, and to receive a timely and professional response to their complaint in compliance with the HealthChoices Program Standards and Requirements Appendix H. This Complaint process is managed by Magellan's Quality Improvement Team. Complaint information is integrated as a key indicator for informing patient safety, credentialing, quality improvement activities, and analyzed for trending and opportunities throughout the network.

When a member files a complaint directly with Magellan, Magellan partners with the provider to address the concern. A member's decision to file a complaint with Magellan should not compromise their care or services. Providers are expected to adhere to their Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures. The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. If Magellan identifies a supported (substantiated) complaint involving an agency, Magellan staff will collaborate with providers to develop a Complaint Resolution Plan to address the concern. Please review the Provider Communication shared with network providers here about this important and collaborative process.

Grievance Process

Magellan and the Pennsylvania HealthChoices Program Standards and Requirements defines a grievance as a request by a member, the member's representative or health care provider (with written consent of the member), to have Magellan or a utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

Magellan reviews requests from providers for behavioral health services to ensure that approved services are medically necessary and appropriate.

If a level-of-care request is not authorized at the level, frequency or duration as requested, Magellan members are entitled to grieve a medical necessity denial. At the time of a denial, Magellan informs members of this right and how to proceed. Each medical necessity grievance is handled in a timely manner consistent with the clinical urgency of the situation and in compliance with the HealthChoices Program Standards and Requirements Appendix H.

If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member, and the member's family if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the treatment plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Complaint and Grievance Information and Resources

Network providers are required to display information at their offices about how to file a Complaint or a Grievance, the Complaint and Grievance process, and notice that Members will not incur a fee for filing Complaints or Grievances at any level of the process.

For additional information about Complaints and Grievances, including provider-initiated grievances and filing a provider complaint, please visit the Complaint and Grievance page of the Magellan of Pennsylvania website at https://www.magellanofpa.com/for-providers/services-programs/complaints-grievances/ and the Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers.

Quality Management

Quality care for members and their families is important. Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and services. Magellan has collaborated with Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

Magellan's Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA). Assessment of compliance with these requirements is integrated into our quality improvement activities.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures and activities. Providers shall permit access to any and all portions of the medical record that resulted from member's admission or the services provided. Magellan's utilization review program and/or quality improvement program may include on site review of covered services and shall permit Magellan staff on site access.

In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members in order to provide, safe, effective, patient-centered, timely, and equitable care in a culturally sensitive manner. Please refer to the Magellan National Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information and guidelines.

In addition to adhering to state and federal regulations, providers are responsible to:

- Follow policies and procedures outlined in Magellan's Provider Handbook and Provider Handbook Supplement.
- Meet treatment record standards as outlined in the Treatment Record Review Tool found under Audit Tools in the Appendix of Magellan's Provider Handbook.
- Provide treatment records as requested for quality of care issues and adhere to clinical practice guidelines and HEDIS®-related measures.
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities.
- Use evidence-based practices.
- Adhere to principles of member safety.
- Attend or log on to provider training and orientation sessions.
- Participate in the completion of a remediation plan if quality of care concern arises.
- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together.
- Incorporate the use of secure technology into their practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, electronic referrals to other practitioners or programs, and online access to personal health record information.
- Assist in the investigation and timely response of member complaints.
- Assist in the investigation and timely response of adverse incidents.

Magellan commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective that respects individual member preferences, needs and values, and is sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices deeply rooted in cultural competence and prioritize health equity and inclusion. These practices include focusing on continual training and education to support staff. Cultural Competence and Diversity, Equity, and Inclusion (DEI) resources are available on www.Magellanofpa.com to help develop provider cultural competency programs.

There are instances where Members may benefit from oral interpretation, translation services, and materials/communication approaches in non-English languages or alternative formats. Providers are encouraged to maintain staff training to support Members with language assistance needs and ensure that their team is prepared to respond to provide the best possible treatment outcomes. Magellan offers language assistance service educational resources for network providers. These are located on Magellan's website.

Please note: Reporting requirements for Magellan remain consistent and in line with the PA DHS Bulletin, OMHSAS-15-01. A copy of all reportable incidents must be submitted to Magellan's Quality Management Department within 24 hours of an incident or upon notification of an incident. The types of incidents that are reported to Magellan include: Death, Attempted Suicide, Significant Medication Error, Need for Emergency Services, Abuse/Childline Report, Neglect, Injury/Illness, Missing Person, Seclusion, Restraint, Other (https://www.magellanprovider.com/media/29919/adverseincidentreporting.pdf).

Appendix A to the Pennsylvania HealthChoices Supplement to the Magellan National Provider Handbook offers an updated Incident Reporting Form, Provider Instructions and Definitions. Magellan also provides an electronic format for incident reporting for submission to ease provider paper burden.