309-019-0225

Assertive Community Treatment (ACT) Overview

(1) The Substance Abuse and Mental Health Services Administration (SAMHSA) characterizes ACT as an evidence-based practice for individuals with a serious and persistent mental illness. ACT is characterized by:

(a) A team approach;

(b) Community based;

(c) A small client to staff caseload, typically 10:1, to consistently provide necessary staffing diversity and coverage;

(d) Time-unlimited services;

(e) Flexible service delivery;

(f) A fixed point of responsibility; and

(g) 24/7 crisis availability.

(2) ACT services include, but are not limited to:

(a) Hospital discharge planning;

(b) Case management;

(c) Symptom management;

(d) Psychiatry services;

(e) Nursing services;

(f) Co-occurring substance use and mental health disorders treatment services;

(g) Vocational services;

(h) Life skills training; and

(i) Peer support services.

(2) SAMHSA characterizes a high fidelity ACT Program as one that includes the following staff members:

a) Psychiatrist or Psychiatric Nurse Practitioner;

b) Psychiatric Nurse(s);

c) Qualified Mental Health Professional (QMHP) ACT Team Supervisor;

d) Qualified Mental Health Professional(s) (QMHP) Mental Health Clinician;

e) Substance Abuse Treatment Specialist;

f) Employment Specialist;

g) Housing Specialist;

h) Mental Health Case Manager; and

i) Certified Peer Support Specialist.(3) SAMHSA characterizes a high fidelity ACT Program as one that adheres to the following protocols:

a) Explicit admission criteria that has an identified mission to serve a particular population and uses measurable and operationally defined criteria;

b) Intake rate: ACT eligible individuals are admitted to the program at a low rate to maintain a stable service environment;

c) Full responsibility for treatment services which includes, at a minimum, case management, psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services;

d) Twenty four-hour responsibility for covering psychiatric crises;

e) Involvement in psychiatric hospital admissions;

f) Involvement in planning for hospital discharges; and

g) Time-unlimited services.

309-019-0230

ACT Provider Qualifications

(1) In order to be eligible for Medicaid or State General Fund reimbursement, ACT services shall be provided only by those providers meeting the following minimum qualifications:

(a) The provider must hold and maintain a current certificate under OAR 309-008, issued by the Division, for the purpose of providing behavioral health treatment services; and

(b) The provider must hold and maintain a current certificate, issued by the Division, under OAR 309-019-(INSERT ACT FINAL NUMBER RNAGE FOR RULE), for the purpose of providing Assertive Community Treatment; and

(c) A provider certified to provide ACT services under this rule must be reviewed annually for fidelity adherence by the Division approved reviewer and achieve a minimum score of 114 on the fidelity scale. Providers shall not bill Medicaid or use General Funds unless they are subject to an annual fidelity review by the Division approved reviewer.

(A) The Division approved reviewer shall forward a copy of the annual fidelity review report to the Division approved reviewer and provide a copy of the review to the provider.

(B) The provider shall forward a copy of the annual fidelity review report to the appropriate CCO.

(2) A Provider already holding a certificate of approval under OAR 309-008 may request the addition of ACT services be added to their certificate of approval via the procedure outlined in OAR 309-008-0400 and 309-008-1000(1).

(a) In addition to application materials required in OAR 309-008 and this rule, the provider must also submit to the Division a letter of support which indicates receipt of technical assistance and training from the Division approved ACT reviewer.

309-019-0235

Continued Fidelity Requirements

(1) In addition to the minimum requirements established in OAR 309-019-0230, in order to maintain a ACT provider designation on the Division issued certificate, a provider must submit to their CCO an annual fidelity review report by the Division approved reviewer with a minimum score of 114.

(2) Providers certified to provide ACT services under this rule that achieve a fidelity score of 128 or better when reviewed by the Division Approved ACT Reviewer are eligible to extend their fidelity review period to every 18 months.

(a) Extension of Fidelity reviews has no bearing on the frequency of re-certification reviews required under OAR 309-008.

(3) Fidelity reviews will be conducted utilizing the Substance Abuse and Mental Health Services ACT Toolkit Fidelity Scale, which will be made available to providers electronically

309-019-0240

Failure to Meet Fidelity Standards

(1) In addition to any plan of correction requirements issued by the Division under 309-008-0800(4)(c); If a Provider certified under these rules to provide ACT services does not receive a minimum score of 114 on a fidelity review, the following shall occur:

(a) Technical assistance shall be made available by the Division approved reviewerreviewer for a period of 90 days to address problem areas identified in the fidelity review;

(b) At the end of the 90 day period, a follow-up review will be conducted by the Division approved reviewer; and

(c) The provider shall forward a copy of the amended fidelity review report to the provider's appropriate CCO.

(d) The Division approved reviewer shall forward a copy of the fidelity review report to the Division.

(2) In addition to the standards set for suspension and revocation of a certificate in OAR 309-008-1100(1) & (2) a provider of ACT services may also have their certificate of approval suspended or revoked if the 90 day re-review results in a fidelity score of less than 114.

(1) A provider issued a notice of intent to apply a condition, revoke, suspend, or refusal to renew its certificate under these rules shall be entitled to request a hearing in accordance with ORS Chapter 183 and OAR 309-008-1300.

309-019-0245

Admission Criteria

(1) Participants must meet the Medically Appropriate standard as designated in OAR 309-019-0105. Participants who are Medically Appropriate must have the following characteristics:

(a) Participants diagnosed with severe and persistent mental illness as listed in the Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability.

(b) Participants with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder or intellectual disabilities are not the intended client group.)

(c) Participants with significant functional impairments as demonstrated by at least one of the following conditions:

(A) Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

(B) Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).

(C) Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

(d) Participants with one or more of the following problems, which are indicators of continuous high service needs (i.e., greater than eight hours per month):

(A) High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.

(B) Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).

(C) Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months).

(D) High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).

(E) Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.

(F) Residing in an inpatient or supervised community residence in the community where ACT services are available, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.

(G) Difficulty effectively utilizing traditional office-based outpatient services.

Use of Assertive Community Treatment in Licensed Residential

(1) ACT services may not be provided to individuals residing in an RTF or RTH licensed by HSD unless the individual:

(a) is not being provided rehabilitative services; or

(b) the individual has been identified for transition to ACT services in the community the individual intends to reside upon discharge from the RTF or RTH.

(A) When identified for transition to a less intensive level of care the individual may receive ACT services for up to six months prior to discharge form the RTH or RTF.

Admission Process:

(1) A comprehensive assessment as described in OAR 309-019-0105 (6) that demonstrates medical appropriateness must be completed prior to the provision of this service. If a substantially equivalent assessment is available, that reflects current level of functioning, and contains standards consistent with OAR 309-019-0135, to include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services, the equivalent assessment may be used to determine admission eligibility for the program.

(2) Admission to ACT is managed through a referral process that is coordinated by a designated single point of contact (SPOC) that represents the Coordinated Care Organization's (CCO) and/or Community Mental Health Program's (CMHP) geographical service area.

(a)The designated single point of contact shall accept referrals and verify the required documentation supports the referral for services.

(b) OHA will work with the CCOs and the CMHPs to identify regional SPOCs.

(c) OHA will work with the CCOs and the CMHPs to identify a process where referrals can be received and tracked.

(3) An admission decision by the designated SPOC must be completed and reported to the Division within seven (7) business days of receiving the referral. To accomplish this, the SPOC must be fully informed as to the current capacity of ACT programs within the SPOC's geographic service area at all times.

(4) All referrals for ACT services must be submitted through the designated regional SPOC, regardless of the origin of the referral. The designated regional SPOC shall accept and evaluate referrals from mental health outpatient programs, residential treatment facilities or homes, families and/or individuals, and other referring sources.

(5) Given the severity of mental illness and functional impairment of individuals who qualify for ACT-level services, the final decision to admit a referral rests with the provider. Any referral to a provider should therefore present a full picture of the individual by means of the supporting medical documentation attached to the OHA Universal ACT Referral and Tracking Form. An admission decision by the ACT services provider must be completed within five (5) business days of receiving the referral.

(a) The individual's decision not to take psychiatric medication is not a sufficient reason for denying admission to an ACT program.

(b) ACT capacity in a geographic regional service area is not a sufficient reason for not providing ACT services to an ACT eligible individual. If an individual who is ACT eligible cannot be served due to capacity, the SPOC must provide individual with the option of being added to a waiting list until such time the ACT eligible individual can be admitted to a qualified ACT program.

(6) Upon the decision to admit an individual to the ACT program, the OHA Universal ACT Referral and Tracking Form shall be updated, to include:

(a) An admission is indicated.

(b) When an admission is not indicated, notation shall be made of the following:

(A) The reason(s) for not admitting;

(B) The disposition of the case; and

(C) Any referrals or recommendations made to the referring agency, as appropriate.

(7) Individuals who meet admission criteria and are not admitted to an ACT program due to program capacity, may elect to be placed on a waiting list. The waiting list will be maintained by the appropriate regional SPOC. OHA will monitor each regional waiting list until sufficient ACT program capacity is developed to meet the needs of the ACT eligible population.

(8) In addition if an individual is denied ACT services and has met the admission criteria set forth in OAR 309-019-045, the individual who is denied services or their guardian may appeal the decision by filing a grievance in the manner set forth in OAR 309-008-1500.

309-019-0250

Transition to Less Intensive Services

(1) Transition to less intensive services shall occur when the individual no longer requires ACT level of care and is no longer medically appropriate for ACT services. This shall occur when individuals receiving ACT:

(a) Have successfully reached individually established goals for transition.

(b) Have successfully demonstrated an ability to function in all major role areas (i.e. work, social, and self-care) without ongoing assistance from the ACT provider;

(c) When the individual requests discharge, declines, or refuses services; and

(c) When the individual moves outside of the geographic area of the ACT program's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT provider or another provider wherever the individual is moving. The ACT team shall maintain contact with the individual until this service is implemented.

309-019-060

Grievances and Appeals

(1) Any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with the provider, the individual's managed care plan or the Division.

(2) For individuals whose services are funded by Medicaid, grievance and appeal procedures outlined in OAR 410-141-0260 through 410-141-0266, must be followed.

(3) For individuals whose services are not funded by Medicaid, providers must comply with complaint procedures regulated by OAR 309-008-1500.

309-019-060

Reporting Requirements

Providers certified by the Division to provide ACT shall submit quarterly outcomes reports, using forms and procedures prescribed by the Division, within 45 days following the end of each subject quarter to the Division or the Division approved reviewer. Each quarterly report shall provide the following information:

1) Individuals served;

(a) Individuals who are homeless at any point during a quarter;

(b) Individuals with safe stable housing for 6 months;

(c) Individuals using emergency departments during each quarter for a mental health reason;

(d) Individuals hospitalized in OSH or in an acute psychiatric facility during each quarter;

(e) Individuals hospitalized in an acute care psychiatric facility during each quarter;

(f) Individuals in jail at any point during each quarter;

(g) Individuals receiving Supported Employment Services during each quarter;

(h) Individuals who are employed in competitive integrated employment, as defined above.

2) Individuals receiving ACT services that are not enrolled in Medicaid

3) Referrals and Outcomes

(a) Number of referrals received during each quarter;

(b) Number of individuals accepted during each quarter;

(c) Number of individuals admitted during each quarter; and

(d) Number of individuals denied during each quarter and the reason for each denial.