

Program of Assertive Community Treatment

Program of Assertive Community Treatment, PACT is an intensive community-based program that uses a multi-disciplinary team of behavioral health professionals and trained peers to provide or coordinate treatment, rehabilitation, and community support services for members who are recovering from severe mental health conditions. Program Assertive Community Treatment is focused on addressing the factors that precipitated access to this service (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated without the support of Program Assertive Community Treatment.

Program Assertive Community Treatment services may be mobile or delivered within an outpatient treatment setting, and are available 24 hours a day, 7 days a week.

Program Assertive Community Treatment services vary in intensity, frequency, and duration in order to support the member’s ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

Program Assertive Community Treatment must meet Medical Necessity Criteria per TennCare Rules 1200-13-16-.05*

Admission Criteria (must meet all of the following):

1. The member is eligible for benefits.
2. The member’s condition and proposed services are covered by the benefit plan.
3. Services are within the scope of the provider’s professional training and licensure.
4. The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors (i.e., the factors leading to admission).
5. Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.

6. The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the factors leading to admission) require the intensity of services provided in the proposed level of care.
7. Co-occurring medical conditions can be safely managed.
8. Services are the following:
 - a. Consistent with generally accepted standards of clinical practice;
 - b. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;
 - c. Consistent with Optum's best practice guidelines;
 - d. Clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.
9. There is a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time.
 - a. Improvement of the member's condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.
 - b. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member's recovery, resiliency and wellbeing.
10. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.
11. The member is not in imminent or current risk of harm to self, others, and/or property.

Continued Service Criteria (must meet all of the following):

1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active" services must be as follows:
 - a. Supervised and evaluated by the admitting provider;
 - b. Provided under an individualized treatment plan that is focused on addressing the precipitating factors and makes use of clinical best practices;
 - c. Reasonably expected to improve the member's presenting problems within a reasonable period of time.
2. The precipitating factors leading to admission have been identified and are integrated into the treatment and discharge plans.
3. Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.
4. The member's family and other natural resources when available are engaged to participate in the member's treatment as clinically indicated.

Discharge Criteria (must meet one of the following):

1. The continued stay criteria are no longer met. Examples include:

- a. The precipitating factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.
- b. The precipitating factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
- c. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
- d. The member requires medical-surgical treatment.
- e. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.

Evaluation & Treatment Planning:

1. Evaluation & Treatment Planning

- a. The initial evaluation:
 - i. Gathers information about the presenting issues from the member's perspective, and includes the member's understanding of the factors that lead to requesting services (i.e., the precipitating factors);
 - ii. Focuses on the member's specific needs;
 - iii. Identifies the member's goals and expectations;
 - iv. Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- b. When available, the provider collects information from the member and other sources, and completes an initial evaluation of the following:
 - i. The member's chief complaint;
 - ii. The history of the presenting illness;
 - iii. The precipitating factors leading to the request for service;
 - iv. The member's mental status;
 - v. The member's current level of functioning;
 - vi. Urgent needs including those related to the risk of harm to self, others, or property;
 - vii. The member's use of alcohol, tobacco, or drugs;
 - viii. Co-occurring behavioral health and physical conditions;
 - ix. The history of behavioral health services;
 - x. The history of trauma;
 - xi. The member's medical history and current physical health status;
 - xii. The member's developmental history;
 - xiii. Pertinent current and historical life information including the member's :
 - 1. Age
 - 2. Gender, sexual orientation
 - 3. Culture
 - 4. Spiritual beliefs
 - 5. Educational history
 - 6. Employment history
 - 7. Living situation
 - 8. Legal involvement
 - 9. Family history

10. Relationships with family and other natural resources

- xiv. The member's strengths
- xv. Barriers to care
- xvi. The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
- xvii. The member's broader recovery, resiliency and wellbeing goals.
- c. The provider uses the findings of the evaluation to assign a DSM/ICD diagnosis.
- d. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses the following:
 - i. The short- and long-term goals of treatment;
 - ii. The type, amount, frequency and duration of treatment;
 - iii. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the precipitating factors;
 - iv. How the member's family and other natural resources will participate in treatment when clinically indicated;
 - v. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.
- e. As needed, the treatment plan also includes interventions that enhance the member's motivation, promote informed decisions, and support the member's recovery, resiliency, and wellbeing. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- f. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
- g. Treatment focuses on addressing the precipitating factors to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
- h. The treatment plan and level of care are reassessed when the member's condition improves, worsens or does not respond to treatment.
 - i. When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
 - ii. When the member's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member's condition should be treated in another level of care.
- i. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.
- j. The PACT team is coordinated by a responsible provider (PACT Team Coordinator) who:
 - i. Is a behavioral health provider;
 - ii. Has knowledge and competencies that meet the member's needs;

- iii. Provides clinical supervision of the Program Assertive Community Treatment team;
 - iv. Provides direct services to the member.
- k. The PACT team includes a psychiatrist who:
 - i. Provides assessment and treatment services;
 - ii. Participates in team meetings; and
 - iii. Provides clinical supervision in conjunction with responsible provider and case consultation.
- l. The PACT Team Coordinator in conjunction with the Program Assertive Community Treatment team completes the initial evaluation within 24 hours of admission. The focus of the initial evaluation is on the member's mental and functional status, the effectiveness of past treatment, and the member's current needs for treatment, rehabilitation, and support services. The initial evaluation guides services until the comprehensive assessment and Program Assertive Community Treatment plan are completed.
- m. The PACT Team Coordinator in conjunction with the Program Assertive Community Treatment team completes a comprehensive assessment within one month of admission. The comprehensive assessment builds on information obtained during the initial assessment, and is used to Program Assertive Community Treatment plan.
- n. The responsible provider in conjunction with the Program Assertive Community Treatment team and, whenever possible, the member develops a multidisciplinary service plan that addresses the following:
 - i. Behavioral health illness or symptom reduction;
 - ii. Housing;
 - iii. Activities of Daily Living;
 - iv. Daily structure and employment;
 - v. Family and social relationships.
- o. The service plan includes a crisis intervention plan.
- p. The Program Assertive Community Treatment team provides services such as the following to the member's family with the member's consent:
 - i. Education about the member's condition and its treatment;
 - ii. Education about the member's strengths;
 - iii. Education about the family's role in the member's treatment;
 - iv. Assistance with resolving conflicts;
 - v. Interventions aimed at promoting the family's collaboration with the PACT team.
- q. On average the member is seen 3 times per week. The Program Assertive Community Treatment team has the capacity to see the member more frequently. Reasons for more frequent contact include:
 - i. The member's signs and symptoms have worsened.
 - ii. The member response to a new medication needs to be monitored.
 - iii. The member is experiencing an acute serious life event.
- r. The Program Assertive Community Treatment team psychiatrist assesses the member's signs and symptoms, prescribes appropriate medication, and monitors the member's response to the medication.

- s. The Program Assertive Community Treatment team provides ongoing support and liaison services for members who are hospitalized or incarcerated.
 - t. The Program Assertive Community Treatment team reaches out and maintains contact with the member when the member becomes isolated or is admitted to a higher level of care.
 - u. The Program Assertive Community Treatment team conducts regularly scheduled planning meetings. The purpose of planning meetings is to:
 - i. Ensure that staff remain familiar with each member's Program Assertive Community Treatment plan;
 - ii. Provide an opportunity to assess the member's progress and reformulate the Program Assertive Community Treatment plan as needed;
 - iii. To problem-solve treatment issues;
 - iv. To obtain input from the member, and incorporate the member into decisions about the Program Assertive Community Treatment plan.
 - v. The service plan is reviewed and modified as necessary commensurate with the member's needs, or no less than quarterly.
2. Discharge Planning
- a. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
 - b. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:
 - i. An appropriate discharge plan is in place prior to discharge;
 - ii. The discharge plan is designed to mitigate the risk that the precipitating factors which precipitated admission will reoccur;
 - iii. The member agrees with the discharge plan.
 - c. For members continuing treatment:
 - i. The discharge plan includes the following:
 - 1. The discharge date;
 - 2. The post-discharge level of care, and the recommended forms and frequency of treatment;
 - 3. The names of the providers who will deliver treatment;
 - 4. The date of the first appointment including the date of the first medication management visit;
 - 5. The name, dose and frequency of each medication;
 - a. A prescription sufficient to last until the first medication management visit is provided;
 - b. An appointment for necessary lab tests is provided;
 - 6. Resources to assist the member with overcoming barriers to care such as lack of transportation or child care;
 - 7. Recommended self-help and community support services;
 - 8. Information about what the member should do in the event of a crisis prior to the first appointment.
 - ii. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the precipitating factors which led to admission will reoccur.
 - iii. The provider shares the discharge plan and all pertinent clinical

- information with the providers at the next level of care prior to discharge.
- iv. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.
 - 1. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.
- v. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.
- d. For members not continuing treatment:
 - i. The discharge plan includes the following:
 - 1. The discharge date;
 - 2. Recommended self-help and community support services;
 - 3. Information about what the member should do in the event of a crisis or to resume services.
 - ii. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

References

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***Medical necessity criteria per TennCare Rule 1200-13-16-.05**

1. Services must be recommended by a licensed physician who is treating the enrollee or recommended by another licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee.
2. Services must be required in order to diagnose or treat the member's medical condition.
3. Services must be safe and effective.
4. Services must not be experimental or investigational.
5. Services must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

**Per TennCare, a licensed clinician practicing within the scope of his or her licensure must either assess the individual or review and approve the treatment plan within 30 days of the date of referral. UHCCP requires this individual to be identified at the time of the authorization request and available for peer-to-peer review if needed.